

APPENDICES

APPENDIX 1

CELL NO: <u>11</u>	CUSTODY NO: <u>24/19998</u>	
STATION: <u>Rice HQ, Durong</u>	SCRO No. (for Court Team Use) <u>574150/02K</u>	
ARRIVAL TIME/DATE <u>0600hrs 28/11/03</u>		
NAME: <u>Kristofer Batt</u>		
DATE OF BIRTH: <u>8/2/1990</u>		
☒ ARREST / ☒ WARRANT / REMAND / DETENTION (ARRESTED / RELEASED) *Delete as appropriate CHANGE OF DETENTION STATUS: TIME / DATE: _____		
STATEMENT TO PRISONER: YOU ARE GOING TO BE ASKED QUESTIONS IN RELATION TO YOUR CARE AND WELFARE WHILST IN CUSTODY. IT IS IMPORTANT THAT YOU ANSWER THESE QUESTIONS ACCURATELY AND HONESTLY. (THE PRISONER MUST NOW BE ASKED QUESTIONS 1 - 9 DETAILED OVERLEAF)		
VULNERABILITY ENTER HIGH / LOW IN RED	<u>LOW</u>	FREQUENCY OF VISITS <u>Monthly</u>
SPECIAL RISK (IF YES INSERT LARGE ASTERISK IN RED)		<u>*</u>
OFFICER ASSESSING:	Signature: <u>Alan K. A.</u>	Rank: <u>PS</u> No. <u>8034</u>
CHANGES TO VULNERABILITY (Reason for changes to be entered on ADM 51(a))	ENTER HIGH / LOW IN RED	FREQUENCY OF VISITS
OFFICER ASSESSING	Signature: _____ Time / Date: _____	Rank: _____ No. _____
CHANGES TO VULNERABILITY (Reason for changes to be entered on ADM 51(a))	ENTER HIGH / LOW IN RED	FREQUENCY OF VISITS
OFFICER ASSESSING	Signature: _____ Time / Date: _____	Rank: _____ No. _____

REASON FOR ARREST DETENTION PSC Appoint breach of bail

VULNERABILITY ASSESSMENT QUESTIONS - IF 'YES' TO ANY QUESTION, OBTAIN FURTHER DETAILS

1. Are you suffering from any injury?	YES ☐ NO ☒
2. Are you suffering from any illness or medical condition?	YES ☐ NO ☒
3. Are you taking ANY medication?	YES ☐ NO ☒
4. Do you take any other kind of drugs? (including cannabis)	YES ☐ NO ☒
5. Do you suffer from any form of alcohol dependency?	YES ☐ NO ☒
6. Have you used any drugs or consumed any alcohol within the last 24 hours? (If yes, which substance, when and how much?)	YES ☐ NO ☒ Drink: Type _____ Drugs: Type _____ Time: _____ Quantity: _____ Time: _____ Quantity: _____
7. Do you suffer from, or have you ever suffered from any form of mental illness or disorder?	YES ☒ NO ☐ <u>ADHD</u>
8. Have you ever committed any acts of self harm or attempted suicide?	YES ☐ NO ☒
9. Do you have any other relevant information relating to your personal care and welfare whilst in custody?	YES ☐ NO ☒
10. Do you have any special dietary requirements or food allergies?	YES ☐ NO ☒
If the prisoner has failed, or refused, to answer any of the above questions, please state reasons	REASONS
Arresting officer must be asked - "Have you given ALL information regarding this prisoner including their earlier conduct, which will enable accurate assessment of their custody care arrangements e.g. has level of consciousness varied?"	Reply - YES ☒ NO ☐ (Additional information) <u>SURRENDERED AT MED.</u>

REASON FOR VULNERABILITY	
REASON FOR SPECIAL RISK	<u>Self-harmers firearms violent</u> <u>mental ailment</u> <u>appears under influence of drink or drugs on arrest</u>
REASON FOR STRIP SEARCH AND AUTHORISED SUPERVISOR	
NEEDLE EXCHANGE SCHEME IF YES, 1ML OR 2ML NEEDLE PACK GIVEN	YES / NO

No. 11

Highlight in 'RED' any changes to 'VULNERABILITY' status or frequency of visits in the Remarks column

Name of prisoner Kristoffer Batt

Date & Time	Officer Incl. Rank & No.	Medication Type and Dosage	A verbal response must be obtained on every visit. REMARKS: To include all movements, risks, fingerprints, photographing, interviews, meals, drinks etc.
04.12.21	ADK AS 8034		TO all ^{PRISONERS} PRISONERS .
0800	A		LISTERED
0802	A		SITTING UP - 13 OK
0706	What cat took		GRANTUS
0736	AS		PRISONER NOT RESPONSIVE Cushing Synd.
0738	W/Prison		Called to Cell re.
			Prisoner Not responding
			Arrived + A. S. Smith
			+ J. Masson being asked
			advised. Continued by
			Adams + Assisted
			by L. Norman.
			Ans. Called + Instructed.
			Control Information
0738	W/Prison		Substance Arrived +
			begin working on
			Prisoner.
0803	W/Prison		Have now been working
			on Prisoner for 15
			Mins. No response.
			They will continue for
			5 more minutes.
0809	W/Prison		No response. Life Mon.
			Extant by Adv. Staff.
			Byrne David Kumar.
			Rebecca Taylor Anderson.

ADM 51(a)

Highlight in 'RED' any changes to 'VULNERABILITY' status or frequency of visits in the Remarks column

Kristopher Barr

[illegible]



TAYSIDE POLICE AT RISK PRISONER

THE UNDERNOTED PRISONER IS BELIEVED TO BE IN THE AT RISK CATEGORY.

Surname: BATT Forename(s): KRISTOFFER DoB: 8/2/1957
Custody Ref. No: C4/19898/5 Date: 28/1/15 SCRO No: 574152/021
Charges: DSC Non Appearance arrest for Breach of
bond

At Risk Form raised by

Name: LINDSEY DON Rank: PC
Station: H2 Tel. No: -
Supervisor: SGT KFM Date: 28/1/15

AT RISK CATEGORIES

- | | | | |
|------------------------------------|-------------------------------------|--|-------------------------------------|
| 1 Violent | ☒ | 7 Sufferer of a serious infectious disease | ☐ |
| 2 Likely to escape | ☐ | 8 Mental instability | ☒ |
| 3 Associates may attempt rescue | ☐ | 9 Physical illness | ☐ |
| 4 Suicidal tendencies | ☐ | 10 Physical injury | ☐ |
| 5 Known drug/alcohol dependency | ☐ | 11 Requires protective/segregation | ☐ |
| 6 On medication/medical conditions | ☐ | 12 Other (specify) | ☐ |

Where a risk has been identified, the reason(s) MUST be given below. If medical raised include details of doctor:

SGT Freeman, violent, mental, ailment
Arrested under influence of drink or drugs on arrest

Duty Officers should attach their notes with this form

PRISONER MOVEMENTS

From:	Date:	To:	Officer Receiving:

APPENDIX 2

Hearing in relation to alleged contempt of court by Stuart Lewis in Fatal Accident Inquiry into the death of Kristopher Batt

[1] On a reference from Sheriff Elizabeth Munro who had presided over a Fatal Accident Inquiry into the death of Kristopher Batt in police custody on 28th. November, 2007, I was asked to determine whether a witness, Stuart Lewis, who was and is an employee of Tayside Police, in the capacity of custody care assistant, had committed an act or acts consistent with being in contempt of court while giving evidence on 14th. and 15th. May, and 29th. June, 2009.

[2] In the statement of facts prepared by my learned colleague, she stated that the alleged acts of contempt fell into two quite distinct categories. The first was the question whether Mr. Lewis had deliberately lied to and misled the court. The second was whether he had prevaricated, that is he had deliberately been obstructive in the answers he gave to the court in the course of his evidence, all with a view to avoiding telling the truth.

[3] The alleged deliberate lie related to evidence given on 14th. and 15th. May, 2009 generally to the effect that at times when the deceased had illuminated a red light at his cell, which would also show up on an illuminated board in the custody care officers' room, Mr. Lewis was working on a computer carrying out work related activity on the computer when he was in fact on the internet. On 29th. June, 2009, Mr. Lewis admitted, having been faced with evidence from an expert who had carried out an examination of the use of the computer which Mr. Lewis had made on 28th. November, 2007, that he had had access to the internet on not less than 59 separate occasions in the course of his shift.

[4] In relation to prevarication, it was said that on 29th. June, 2009, he gave answers which were evasive, inconsistent, equivocal, implausible and incredible prior to being warned about prevarication by Sheriff Munro and that thereafter he continued to give answers which were evasive, equivocal and inconsistent.

[5] Sheriff Munro had to recuse herself from dealing with these issues directly and referred them to me. While the Act of Adjournal (Criminal Procedure Rules Amendment No. 2)(Contempt of Court) 2009, was not in force at any of the dates when the alleged contempt was committed, it was submitted to me by Mr. Dunlop, Advocate, who appeared for the alleged contemnor, that these rules provided a useful template for a virtually unprecedented procedure and I agreed with that submission. Accordingly, the foresaid statement of facts was prepared by Sheriff Munro and answers denying the assertions therein contained were lodged on behalf of Mr. Lewis. There was then further discussion as to the format of any hearing. Having heard from Mr. Dunlop thereon, I issued a deliberately brief judgment on 9th. November to the effect that the hearing would proceed having regard to the content of the transcription of the proceedings and, if necessary, by listening to the tape recordings of the relevant portions of the proceedings. In his submissions to me, Mr. Dunlop proposed that it remained incompetent to require a superior judge to give evidence and that it should only be with the greatest of circumspection that an inferior court judge should be called to give evidence and that this should be avoided where it could be done. I suggested that that sat somewhat unhappily with observations by the Lord Justice Clerk in the judgment of the Court in *Robertson and Gough v HMA* 2008 JC 146, especially at para. 80 about the importance of the position of the judge of first instance seeing and assessing the conduct at first hand and being able to assess its seriousness in the context of the relevant litigation. He said in terms,

“In the case of prevarication, the judge can assess the quality of the witness’s evidence in the context of the issues in the trial and, it may be, the evidence that has preceded it. The judge must give effect to these advantages. Having observed the procedural safeguards to which I shall refer, he should decide whether a contempt has occurred and, if so, deal with it appropriately. If he proceeds in this way, the deterrent effect of any penalty imposed is all the greater. As this court observed in *Mayer v HMA* 2005 1 J.C. 121, in the case of contempt by a witness there is much to be said for the view that, in the administration of justice, prompt and effective steps should be taken to deal with the situation.”

[6] That passage has to be balanced by the considerations set out by the Lord Justice Clerk at para [83] of the same judgment where he says, “In my opinion, where a question of contempt arises in the course of a trial, the judge should be conscious of the ever present danger of over-reaction. The power to deal summarily with contempt should be used sparingly and with restraint. It should be exercised only out of necessity to protect the integrity of the court’s procedures, and preferably only after time for reflection. In all questions of this kind, judges should be cautious in their approach and keep a sense of proportion. Words spoken in heat are sometimes best ignored.” Para [84] is particularly relevant to the present circumstances, “In the case of prevarication, the trial judge may in his discretion let the examination of the witness proceed further to see if the witness thinks better of his attitude. In this way he gives the witness an opportunity to purge his contempt.”

[7] I was thus faced with a difficult balance in deciding whether I should hear evidence which would have required evidence to be taken from Sheriff Munro as well as the depute procurator fiscal, Mr. Keith Robertson, and from the solicitors for Tayside Police, Mr. James Reid and for the deceased’s family, Mr. W.G. Boyle, without the benefit of precognition and

against the clear admonition from authority against compelling an inferior judge to give evidence on the one hand, and a requirement to get a real flavour from such evidence of what really happened at the proceedings on the other. I did not have the benefit of a contradictor to Mr. Dunlop's submission that I should deal with the hearing on the basis of the transcript and the tapes and was seduced by his arguments that that was the best evidence and that calling any judge to give evidence was to be avoided. While on balance I still consider that I came to the correct conclusion, it was not one that I reached with any great enthusiasm.

[8] The Lord Justice Clerk recognised in *Robertson and Gough* at para [99] that there may be exceptional cases where, even though the contempt is not directed personally against the judge, it would be inappropriate for him to deal with the matter himself. At para [102] the desirability of a detailed code of procedure to regulate this was urgently stated. Though I tried to follow that code in the Act of Adjournal, it provides no assistance as to how the second court is to get the flavour from the first court of the allegedly inappropriate behaviour and I found in practice that it was virtually impossible to get any proper sense of the level of seriousness of the behaviour from the transcript and tapes.

[9] As Mr. Dunlop submitted, the primary question was whether, in the course of his evidence on 14th. and 15th. May, 2009 relating to the use he made of computers in the CCA room and the fingerprint room at Tayside Police Headquarters, Dundee, while on the course of his employment as a custody care assistant, he had wilfully misled the court in the answers that he gave. It was his submission that it could not be established beyond reasonable doubt, the criminal standard being the appropriate standard to apply (c.f *Scottish Daily Record and Sunday Mail Limited v Thomson* 2009 J.C. 175), that he had deliberately lied on that occasion when he said, without qualification, that he had not had access to the internet at that time. It

was conceded that that answer had been inaccurate and Mr. Lewis had so conceded in the course of his evidence on 29th. June when the position as disclosed by the expert's findings was put to him. But there was a difference between an answer that was inaccurate and one that was a deliberate lie. In this particular case, Mr. Dunlop drew attention to the fact that in October, 2007, Tayside Police introduced a new computer programme called "Bluecoat" one of the main purposes of which was to restrict internet access to authorised users only. It was not however until February, 2008 that "Bluecoat" became wholly effective, though there was no evidence about precisely when the computers in the CCA room and the fingerprint room ceased to have internet access. Asked on 14th. and 15th. May, 2009 about whether he had internet access on 28th. November, 2007, he had mistakenly assumed that internet access had been withdrawn by that date against a background of having no recollection of using the internet on that date. Mr. Dunlop posed the question, what motive would Mr. Lewis have to lie. He had already conceded that he had not carried out his job properly on that occasion and that he had falsified entries on time sheets relating to visits to the cells of other prisoners, though not to the cell of the deceased. In any event, both the inspector and the sergeant in charge of the shift were aware that he was using the internet as the inspector, Gary Brown, had suggested some sites that he should have a look at. It might be hard to accept that he could not recall what he had been doing on the night in question but he had not been asked about accessing the internet by the police who took his statement and, nineteen months later on, he had genuinely forgotten the true position and convinced himself that internet access had been withdrawn by that night.

[10] The evidence about this has caused me a great deal of concern. In the transcript for 14th. May, 2009, Mr. Lewis makes reference to the computer in the CCAs room. He said at page 10 that he could not remember using the computer in the turnkey's room, as he described it,

but accepted that he might have at the start and at the conclusion of his shift. At page 52, he agrees that he did not have any fingerprinting to do and in answer to the question why was he in the fingerprint room, he said “using the computer within the fingerprint office.” This is the computer around which the disputed evidence centres. He is then asked, “To do what ?” and he answers, “To look at people in custody (inaudible) e-mails, send e-mails, look at the fingerprint (inaudible).” There is then a passage when he was asked in effect whether he was sending official e-mails or e-mails to friends when his answers are confused and contradictory, but insofar as one can get a flavour at second hand of what was going on, the appearance is of a misunderstanding rather than an act of wilful misleading. At the end of 14th. May at page 129, Sheriff Munro is recorded as saying to Mr. Lewis that she wanted to know what he was doing on the computer that night because she did not understand what had taken up so much of his time, so there can be no doubt that he was put on notice by the sheriff that she did not consider what he had said so far in that respect to be satisfactory, and I can understand why. At pages 2 and 3 of his evidence from 15th. May, he appears to misdescribe the time it takes to book someone into a cell on the computer system, but again he seems to concede his original inaccuracy very quickly and that seems consistent with giving a careless answer rather than one which is deliberately misleading. At page 20, he was asked about sending e-mails from the fingerprint room computer and he says that he would have been sending e-mails to colleagues, to a Constable Fearn updating a custody search and possibly also to Divisional Administration. I am not aware of any of that evidence having been explored never mind contradicted. From page 42 onwards, he is asked a series of questions by Sheriff Munro about what he was doing on the computer in the fingerprint room when he says he was “looking at the fingerprint queue and updating the cell sheet ready for handover, looking at the Force intranet, looking at Force bulletins, regional bulletins.” He says he could have been doing these things. He was then asked specifically whether the computer gave him

access to the internet and he unequivocally answered, “No it doesn’t.” That really is the most difficult issue in relation to the first part of the allegation of contempt i.e. the unequivocal nature of that answer. At page 50, he says that all the things he is doing on that computer were “work related.” Other than that, he is not asked any questions about the operation of the computer in the fingerprint room until he is recalled to give evidence on 29th. June, 2009 by which time Mr. Flavell, the computer expert from Tayside Police has already given his evidence and Mr. Lewis has been informed by his solicitor, entirely properly, of the content of Mr. Flavell’s evidence, so he knows that his earlier answers were incorrect and have been demonstrated in evidence to be incorrect. Up to this point, however, it would be very difficult to reach the conclusion that Mr. Lewis had deliberately lied in his evidence. While there is, I suppose, an expectation that people will remember what they were doing on a night in relation to which they had some degree of association with the death of another person, I cannot conclude beyond all reasonable doubt on the basis of that proposition alone that Mr. Lewis deliberately lied when he said that he had no internet access on the night of Kristopher Batt’s death though it is clear beyond any doubt that his answer was inaccurate.

[11] When it comes to the evidence of 29th. June, 2009, first of all at page 8 the deputy procurator fiscal puts to Mr. Lewis documentation which demonstrates what are described as “legitimate business transactions” on the computer system so that, insofar as he claimed in his earlier evidence that he had been making legitimate use of the computer, that documentation appears to bear this out. At page 9, however, he is directed to further documentation which demonstrates he made significant use of the internet via the same computer on the night concerned and that, of course, against the background of his earlier denial of having internet access. He then admits that he had internet access and that on the night in question and at the material times he made use of that internet access and was thus

distracted from his duties of caring for prisoners in custody. I can well understand that such evidence must have been both dramatic and distressing and would have cast Mr. Lewis in a very bad light and generating a presumption that he had been caught lying. He was asked questions about his knowledge of Tayside Police's computer use policies, in relation to which his answers were arguably equivocal but I find it hard to come to an adverse conclusion beyond reasonable doubt. At page 17, he accepts that his response on 15th. May to the effect that he had no internet access on the fingerprint room computer was "not true" and then qualifies that by saying that it was "not correct." Asked to explain why, he explained that on 15th. May to the best of his recollection he did not have internet access at 28th. November, 2007 and that against a background of its planned removal in October, 2007 and its actual removal at some time between 28th. November, 2007 and February, 2008. He was then asked at page 18 onwards about a statement he had made to the police some three weeks after the death of Kristopher Batt in which he was asked what he was doing from 04.12 (when Kristopher Batt was admitted to his cell) onwards when, amongst other things, he said, "I'd also been on the computer on the focus or integrity systems." That seems to have been the truth but nothing like the whole truth and it is very hard to accept that in making that statement at that time to the police that he was being entirely honest with them, but that is a different matter from deliberately misleading the court. He was not asked by the police whether he had been on the internet and so did not deliberately lie by saying he had not been on the internet and again there is a difference between not telling the whole truth, in the sense of not providing the fullest possible answer, and giving a false reply. His answers between page 18 and page 22, which are basically designed to maintain the position that he had forgotten when giving evidence on 15th. May that he still had internet access and had been on the internet, were understandably regarded as unsatisfactory and, had I been able to determine this issues I have to determine on the balance of probability, I would have been inclined to

the conclusion that this was a deliberate lie to conceal the truth that he knew perfectly well that he had been on the internet at the material time, but there are circumstances which give rise to some doubt in my mind about at least the possibility of genuine error and he is entitled to the benefit of that doubt.

[12] The question of prevarication remains. Mr. Lewis's position on 29th. June is plainly a difficult one. He has had to concede giving inaccurate evidence on a previous occasion and his explanation for that was clearly regarded not only by Sheriff Munro but also by Mr. Robertson, the depute procurator fiscal, and Mr. Boyle for the family, as unacceptable and untrue, as can be deduced from their questioning of him. He clearly gets some of his answers wrong and I cannot believe that he expected to be believed when he said, as is recorded at page 25, that he could not remember the following day whether he had been on the internet in the course of the shift at the conclusion of which the fatality occurred. He was taken by Mr. Boyle at some length between that point at page 29 about his ability to recall the events of the preceding day and of course in general terms he could recall the events of the immediately preceding day but his position was consistent that he did not now have any recollection of what he had done on 28th. November 2007 preserved in his memory from the following day when he knew that there had been a death in custody. And while a number of his subsequent answers could easily be regarded as less than satisfactory and could be regarded as an attempt at evasion, if he truly could not remember when first asked about internet access, then his answers do have the merit of consistency. I am inclined to believe that his position was confused because of the knowledge of the true position as disclosed by the expert report and his inability to explain that to himself.

[13] I can also well imagined that Sheriff Munro was singularly unimpressed by the passage of examination and evidence at page 49/50 of 29th. June. Mr. Lewis was asked by Miss Nunn, “Now I think that my friend asked you about when you had given your evidence previously to this inquiry the sheriff had directly asked you whether or not you had been on the internet and (inaudible) asked if you’d been on games and you said ‘no’ to that question, and I think you said to my friend this morning that your position really was that you couldn’t remember ?” Mr. Lewis answered, “Yeah.” Question, “But you hadn’t said that to the Sheriff.” Answer “That’s right.” Question, “You said “No.” Now do you remember getting a direction from the Sheriff about how to answer questions at this inquiry ?” Answer “I did, yes.” Question, “And can you remember what that direction was ?” Answer, “To answer ‘Yes’ and ‘No.’ Question, “And I have in my notes something along the lines of, ‘Do not know or cannot remember will not do.’ Is that your recollection ?” Answer “Yeah.” Question “of what the Sheriff said to you ?” Answer “Yes.” I certainly am unimpressed by that passage and regard the asking of the series of questions as an act of dubious professional propriety on the part of the questioner. This arises from a passage of questioning of Mr. Lewis by Sheriff Munro on 15th. May, 2009 around page 43 of the transcript. The first point is that the question about internet access comes prior to any instruction from the sheriff to answer “Yes” or “No,” so that instruction could not conceivably cover the answer to that question which was the unequivocal “No it doesn’t,” i.e. the computer does not have internet access. The second point is that the instruction is patently directed to Mr. Lewis’s equivocal answer to the question, “Does it have games on it ?” It is simply not possible for any reasonable person to construe the direction as a general direction. And at whatever point the sheriff may have observed that “Do not know or cannot remember will not do,” it was not at a point contiguous to the direction to answer “Yes” or “No” and to suggest the contrary is deliberately misleading. But it is the questions rather than Mr. Lewis’s answers which are so misleading.

[14] Mr. Lewis's position was not assisted by the strange, convoluted and in parts inaccurate questions that Ms. Nunn put to him at page 56 of the transcript of 29th. June. She asks, "Is it your position that in connection with giving this statement to the police on the 17th.

December that you quite accept that it wouldn't have been something out of the norm for you to have been on the internet on the 27th and 28th. November ?" Answer "Yeah." He made his statement to the police on 19th. December, 2007. There has already been discussion about the fact that the police did not ask him about internet access and he did not volunteer that he had been on the internet on the night in question so the question I have just quoted is entirely hypothetical but at first blush the answer appears to be capable of being construed as an admission that Mr. Lewis would, if asked, have said to the police that it would have been normal for him to be on the internet at the material time. The next question was, "And when my friend (Mr. Robertson, depute procurator fiscal) asked you about being on the internet you said that you could have been." Answer "Yes." Question, "And the likelihood is that you were but is it your position that when you were asked three weeks after the event you knew perfectly well that you might have been on the internet, but at that point you couldn't recall if you actually were at the time that were put to you by the police ?" Answer, "That's correct."

Prima facie, these last two questions are meaningless since he was never asked by the police whether he had internet access or whether he had been on the internet on the night of 28th.

November. Read superficially, the answer appears to suggest that Mr. Lewis did know that he might have been on the internet i.e. that he did have internet access, but given the confused and inaccurate nature of the questions, I am not prepared to ascribe that conclusion to him, otherwise I would be driven to the conclusion that in this respect at least he was prevaricating.

[15] In any event, neither in relation to the assertion that he deliberately lied, nor in relation to the assertion that he engaged in prevarication do I feel that I can properly conclude beyond reasonable doubt that Mr. Lewis wilfully misled or attempted to mislead the court and I am therefore not prepared to hold him in contempt.

[16] Mr. Dunlop advanced an *esto* case which, while my decision does not turn on its content, does merit consideration. His submission was that *esto* there was contempt of court whether by lying or prevaricating, in admitting on 29th. June, 2009, as he did, that his earlier answers most particularly on 15th. May had been wrong, by now telling the truth about the situation he had purged his contempt. I suggested that this form of purgation following upon being confronted with irrefutable proof of your inexactitudes was somewhat different from the normal recanting in the course of the same day that some witnesses do when confronted with the consequences of being held in contempt or having committed perjury as the case may be. It was nonetheless his submission that purgation of whatever kind and in whatever circumstances prior to there being a finding of contempt had the effect of rendering what might have been contemptuous no longer contemptuous. Apart from referring me to paragraph [84] of the judgment of the Lord Justice Clerk in *Robertson and Gough* he did not offer any authority for the proposition but instead referred to universal practice. He fairly and properly accepted from me that there was a certain illogic in the position. On the face of it, if there was a need for purging then there must have been something needing purged, but I agree with him that it has been the universal practice of courts in Scotland so far as I am aware to give people the opportunity to think again about *prima facie* contempt and not to make a finding of contempt where the re-thinking process has produced an acceptable response from the potential contemnor. Dr. Griffiths, the District Procurator Fiscal, who appeared at my request as *amicus curiae*, and whose presence, given his vast experience was

of a considerable comfort to me in these unusual circumstances, made it clear that he had taken advice from Crown Counsel as to his function in these proceedings and made it clear to me that that advice had been that his sole function would be restricted to assisting the court with the law, agreed with Mr. Dunlop's submission about the practice in relation to purgation normally resulting in there not being a finding of contempt, and I have no hesitation in accepting that their experience is consistent with my own and the effect of that is that even if I had reached the conclusion that Mr. Lewis had deliberately lied about the issue of internet access on 15th. May, 2009, that, having purged that act of contempt as it would have been, it would not be in accordance with longstanding practice to hold him in contempt, and I would not have done so.

[17] Ill informed observers might reach the conclusion that my decision is at odds with the position of Sheriff Munro and that as a consequence of that there is some implied criticism of her judicial conduct. Nothing could be further from the truth. I hold it as a great privilege to have Elizabeth Munro as a shrieval colleague. She is a judicial officer of outstanding ability and integrity. It would have been very easy to conclude that if she considered that Mr. Lewis was deliberately lying or at least attempting to conceal the truth, then that would be correct. But in fact in these unusual proceedings, that knowledge of a colleague's ability and integrity is something of an albatross for the presiding sheriff in the second court, for to proceed on the suggested foregoing basis would be to act in a manner patently demonstrating bias in favour of that colleague and that would be a fundamental departure from the terms of my judicial oath. I am therefore fortunate, apart from having the benefit of high quality submissions from Mr. Dunlop and Dr. Griffiths, in having the very clear and sound practical guidance, which is in any event binding upon me, set out in the judgment of the Lord Justice Clerk in *Robertson and Gough*. It is made clear for sound practical reasons that the ability summarily to make a

finding of contempt should be used sparingly, with restraint and after time for reflection.

With these considerations in mind and given the unusual nature of this process, I am of the opinion that any act which looked like contempt would have to be stark and without any semblance of explanation before a finding of contempt could be made and that while on the balance of probability I would be inclined to the view that Mr. Lewis at least prevaricated in his evidence, I am not prepared, standing the explanation of sorts advanced by counsel on his behalf, to reach the conclusion that he can be held in contempt, for that explanation has raised a doubt in my mind and Mr. Lewis is entitled to the benefit of that doubt.

APPENDIX 3A

SHERIFFDOM of TAYSIDE CENTRAL & FIFE at DUNDEE

SUBMISSIONS FOR THE CROWN

in relation to the inquiry under Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry

(Scotland) Act 1976

into the circumstances of the death of

KRISTOFFER BATT

- 1 Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:-
- (a) where and when the death and any accident resulting in the death took place;
 - (b) the cause or causes of such death and any accident resulting in the death;
 - (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
 - (d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death; and
 - (e) any other facts which are relevant to the circumstances of the death.

2 **Determination**

Respectfully invites the Sheriff to make the following determination:-

Section 6(1)(a)

That Mr Kristoffer Batt, born 8th February 1990, and latterly of The Old School House, Craichie, Forfar, Angus died on 28th November 2007 between the hours of 0706 and 0746 hours within cell 11, Custody Area, Tayside Police Headquarters, Bell Street, Dundee.

Section 6(1)(b):-

That the cause of Kristoffer Batt's death was the adverse effects of heroin.

Section 6(1)(c):-

The reasonable precaution that could or should have been taken by Tayside Police was the provision of a system of information retention whereby information obtained and relating to drug abuse by Kristoffer Batt upon each episode of custody in which he was involved was available to the Custody Sergeant or Officer responsible to assist in the assessment of his vulnerability.

Section 6(1)(d):-

That there were no defects in any system of working which contributed positively to the death of Kristoffer Batt. Carmichael Sudden Deaths and Fatal Accident Inquiries, 3rd Edition, para 5-76.

Section 6(1)(e):-

That the system of buzzers within the cells area had been deactivated thus removing a possible and additional safeguard for the persons in custody and to better facilitate their welfare.

That a training need exists amongst those employed in the care and welfare of persons in custody to better understand the necessity to communicate with one another regarding the way in which their responsibilities towards those in custody are to be discharged.

SUBMISSIONS FOR THE CROWN

1 Time and Place S6(1)(a)

I have had the benefit of sight of the submissions by my friend Mrs. Nunn on behalf of Stuart Lewis and for the purposes of brevity adopt the terms thereof which are held to be repeated herein brevitatis causa.

2 Cause of Death S6(1)(b)

I have had the benefit of sight of the submissions by my friend Mrs. Nunn on behalf of Stuart Lewis and for the purposes of brevity adopt the terms thereof which are held to be repeated herein brevitatis causa.

3 Precautions (S6(1)(c)

Were there any reasonable precautions which should have been taken that might have avoided Mr Batt's death in terms of Section 6(1) (c) of the 1976 Act?

Insofar as reasonable precautions are concerned, it is accepted that the test is not whether or not there is a reasonable precaution whereby the death or accident resulting in a death "would" have been avoided but only where it "might" have been avoided. What is envisaged by the Act is a real or lively possibility rather than a probability, that the death might have been avoided by taking a reasonable precaution. Reference is made to Carmichael Sudden Deaths and Fatal Accident Inquiries, 3rd Edition, paragraph 5-75.

It is clear from the working practices of Tayside Police quoad persons coming into custody that the question of vulnerability is taken seriously. That the welfare of persons taken into custody is paramount. That is of particular importance when dealing with persons who may be vulnerable owing to the consumption of drink and or drugs.

The principal precaution taken by the Police in addressing the question of vulnerability is a system of assessment of risk. Much evidence was heard at the Inquiry as to how that assessment is carried out, by whom, upon what information the assessment is based and how that information is stored and accessed. Evidence was heard from Sergeant Loudon, Sergeant Kidd and other Officers that if a “drugs marker” was present this would automatically trigger a strip search. The system in place at the time of this death is what is known as Integrity. Referred to in evidence as a stand alone database system. Additionally custody Officers would have reference to SCRO, PNC and CHS which is occasionally supplemented by information from arresting Officers at the Charge bar. Evidence was heard from various Officers regarding the procedure at the Charge bar, that is, the Admin 51, 51a and 19 forms. From the information culled from the various checks and the person’s answers to the Admin. 51 questions a record of a “custody episode” would be recorded on Integrity. The difficulty with the system was that if a person subsequently presented in custody any warning markers noted at a previous custody episode would not automatically transfer to the nominal page for the new episode. Accordingly in a case such as Kristoffer Batt, who did not have previous convictions for Misuse of Drugs, but in respect of whom information had been recorded during previous custody episodes, no information of a drug related nature was available to the Custody Sergeant at the time Kristoffer handing himself in. If that information had been available a strip search would have been carried out which “might” have brought the presence of drugs upon Kristoffer to the attention of the Police and “might” have avoided this unfortunate death.

The precaution which could have been taken to secure this end was easy enough and indeed had previously been utilised. Evidence was heard from Sergeant Loudon (Transcript of 2/6/09 at pages 180 to 182) that such a system had been utilised within his experience and comprised a lever arch file with copies of the Admin. 19 Risk Forms copied into it. These were retained in alphabetical order and replaced every time the Admin 19 form was created which added to the information already held for the custody. He described this as “a useful tool” in his capacity as an experienced Custody Sergeant, simple, cheap and effective.

The lever arch folder system was withdrawn a number of years ago upon advice that it infringed Data Protection legislation. Evidence was heard from Chief Inspector Donald Thomson on 5th June 2009. Mr Thomson is a senior and experienced Officer and at the time of giving evidence was the national Freedom of Information Co-ordinator for the Police Service in Scotland. His evidence was not challenged. Mr Thomson indicated in evidence (Transcript of 5/6/2009 at pages 12 to 20) that what I will describe as the lever arch system did not, as at 28th November 2007, infringe the provisions of and the principles in the Data Protection Act 1998, the terms of which had not been altered since the Act came into force. Put bluntly, there was nothing wrong with the system especially “if it was required to fulfil a duty that a Police Officer had” (Transcript 5/6/09 at page 12).

Further, had such a precaution been taken, most of Kristoffer Batt’s previous custody episodes would have been available to Sergeant Kidd on the morning in question (see Pro. 18, specifically entry dated 20/09/2007, which is an indication of High Vulnerability and Heroin habit). This would have resulted in a higher assessment of vulnerability requiring more frequent observation, a quicker response time to lights and “might” have avoided this unfortunate death.

Evidence was led on behalf of Tayside Police on 29th June 2009 from Detective Superintendent Roderick Ross of Tayside Police. Mr Ross told the Inquiry

(Transcript of 29/6/09 page 83) that the Integrity or UNIFI system was being upgraded, part of the effect of that upgrade being that the information from previous custody episodes (marker) would automatically be updated to the nominal page for a custody, thus ensuring that the maximum amount of relevant information would then be available to the Custody Sergeant or relevant Officer when assessing vulnerability. Unfortunately, as at 29th June 2009, the position remained exactly as it was on the date of Kristoffer Batt's death. In fairness, the upgrade may now have been tested and rolled out. If it has not, that is a matter for grave concern in the absence of some workable alternative as hereinbefore referred to.

4 **Defects in any System of Working(S6(1)(d))**

Nothing to add in respect of this subsection.

5 **Facts relevant to the circumstances of Kristoffer Batt's death (S6(1)(e))**

There was evidence before the Inquiry to the effect that, in addition to cell lights, there was also a system of audible alarms (buzzers) that would sound when a cell light button was pressed from within a cell. The audible alarm would only continue to sound whilst the button was depressed and would sound within the Custody Care Assistants office. The buzzers were working within the Juvenile detention area but had all been deactivated within the cell area. No witness was able to pinpoint when that had been done, who did it or who, if anybody, authorised it. What is, however, clear is that the deactivation of all of the buzzers in the cell area can be viewed as nothing short of lamentable. If the buzzer system is provided, it is there for a purpose. That purpose being to draw the attention of those responsible to a custody requiring attention. There is no evidence which provides a causal connection between this and the death itself. I mention this only in the public interest and note

that the matter was addressed by Inspector Garry Brown of Tayside Police by issuing a memo dated 19th December 2007 (Pro. 76) indicating the procedure to be followed thereafter with regard to the operation of the buzzers and their deactivation.

I have had the benefit of sight of the submissions made by my friend, Mrs Nunn, on behalf of Stuart Lewis. Referring specifically to that part of the submission relating to lack of communication between Mr Lewis and Linda Peddie, appearing at pages 22 and 23 of Mrs Nunn's submissions, for the purposes of brevity, I adopt the terms thereof which are held to be repeated herein brevitatis causa.

APPENDIX 3B

WGB/KF/CIV/B4516 – 19th October, 2009.

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

SUBMISSIONS FOR MICHELLE BATT

as representative of deceased Kristoffer Batt

In relation to the inquiry under Section 6(1)(a) of the Fatal Accidents and Sudden
Deaths Inquiry (Scotland) Act 1976

into the circumstances of the death of

KRISTOFFER BATT

For the purposes of this submission I follow the nomenclature set out in Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act requesting the Sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:-

Section 6(1)(a)

Where and when the death and any accident resulting in the death took place.

Kristoffer Batt died at Tayside Police Station, West Bell Street, Dundee on 18th November, 2007 at a time between 5.10 am and 07.06 am within cell 11, custody area. It is not possible standing the evidence to be more precise. We place no reliance on the alleged visit by Stuart Lewis at approximately 06:01 am. Lewis is so unreliable that no account of what he said he saw, even if it was apparent that he did look into the cells area, should be relied upon. There is no other evidence as to the time of death other than that provided by the daytime civilian staff namely Alistair Smith and David Massie. (See transcript of 11th May, pages 44 and 48), (transcript of 13th May, page 31) and Professor Pounder's evidence (see transcript 5th May at page 142). To place reliance on evidence of a grunt at 7.06 as providing evidence of an exact time of death or the platform for calculating date of death would be unsatisfactory.

Section 6(1)(b)

The cause of Kristoffer Batt's death was the adverse effects of Heroin.

Reference is made to Professor Pounder's evidence as narrated in the transcript of 5th May, 2009 page 116 to Page 122. Reference is also made to the death

certificate. The quantity of heroin *per se* was not the cause of death nor was it due to the deceased consuming diazepam.

Section 6(1)(c)

The reasonable precautions where the death might have been avoided.

Kristoffer Batt's death might have avoided if:

- (a) there had been a proper system devised for the care and custody of prisoners admitted to custody at Tayside Police Station at Dundee;
- (b) that if the so called system devised by Tayside Police, (which was itself inadequate), had been complied with and supervised.
- (c) if two named individuals namely Stewart Lewis and Linda Peddie had carried out the duties entrusted to them.
- (d) If there was an effective supervision system devised and monitored by Tayside Police administrators in respect of the civilian Cell Officers.
- (e) A medical regime in place to administer an opiate antidote by a drug such as Narcolan. A medical regime simply could have been trained Officers able to inject prescribed doses, having been given adequate training.

In respect of Submission 1(a) the evidence overwhelmingly was that there was no proper system. There are so many evidential matters to criticise and were so obvious in evidence I confine myself to the main areas of criticism ranging from the

assessment process, the searching procedures, the classification of risks and the ongoing monitoring of prisoners welfare during the time spent in the custody.

The admission process was defective in that there seemed to be a lack of a coherent process to provide information as to any specific risks in relation to a person in custody. There seemed to be no standardising in the process or the risk management strategy in admitting persons to custody. At the outset, procedures were flawed in relation to the availability of information on certain risks a person in custody presented especially historical information as to his previous admission to a Police Station as to any special risk factors.

The admission process relied on the observations of an arresting officer and the observations of an admitting officer at the Police Station. In passing there may be a difference being the ability of observe in respect of a person arrested committing an offence or arrested in the public street because this will provide a greater level of contact including travelling to a Police Station for an assessment of a prisoner as compared with a Prisoner handing himself in voluntarily. The difference may be with drug users there is a greater opportunity to plan and secrete drugs on their person. Other than it being a consideration in making the admitting officer more vigilant, there does not seem to be a great deal Tayside Police can do about this.

An obvious difficulty with the admission process is that the observation relies greatly upon the honesty of the admitted prisoner. Apart from general criminality,

prisoners suffering from an addiction problem are probably the least likely to be honest in the particular circumstances.

There was no system making accessible accurate custody information forms which had been previously completed at earlier admissions. This lack of a custody information system was a major defect. Such a system could have been provided by filed paper copies or a simple IT system, both capable of meaningful retrieval.

A retrieval system could have provided the Custody Sergeant with information on the previous history and drug involvement of a prisoner. Such information was available to Tayside Police but no senior officer seems to have addressed themselves as to the importance of collating this information in a sensible simple retrieval system. This resulted in the case of Kristoffer Batt of him being wrongly classified as at low risk, not strip searched and not checked every half hour. Had he been correctly classified, he would have been strip searched or at least a more thorough enquiry and history taken from him which may have alerted the Custody Sergeant to what was an obvious danger and which might have resulted in drugs being voluntarily surrendered or at least disclosed in terms of a limited body search. As this information was not available the Custody Sergeant wrongly classified Kristoffer Batt and failed to carry out actions consistent with Kristoffer Batt's known drug usage. This might have resulted in either no drugs being taken to the cells or more frequent checks resulting in a disclosure of drugs to prevent the taking of drugs or to result in more prompt disclosure and obtaining of medical help.

This system, which seemed to have been operated by Tayside Police having commenced with a system of quantifying a risk at the time of admission purported to provide additional safeguards by carrying out repeated timed inspections with additional safeguards involving the use of the prisoner operating a red button system or an audible bell. In passing no-one seems to have applied their mind that the stated time for inspections could have been supplanted by more frequent but less onerous inspections by simply occasionally, outwith formal inspection times, having a quick check through the cell spy-hole.

In any event even the most basic systems put in place by Tayside Police were not complied with in respect that the audible warning systems had been switched off. The red lights were ignored and adequate inspections determined as being essential were not carried out. More alarmingly, no senior officers of Tayside Police seemed to have monitored or noticed these defects including the simple fact of video cameras, which would have at least ensured checks were being carried out at a reasonable time, were not in working order.

The evidence in its entirety clearly discloses a complete lack of supervision by too many senior Police Officers (ie: above Sergeant level to) identify and name who were not supervising civilian cell officers as to the times of checking, the adequacy of checking and the writing up of checking. In Kristoffer Batt's case, this lack of superior officers checking clearly lead to a culture of civilian cell officers being allowed to do very much as they pleased. In the case of Kristoffer Batt, that involved not checking, applying themselves to their own non-working interests while

on work duties and specifically ignoring not just their basic duties but the operation of alarm duties.

Witnesses Lewis & Peddie

My submissions are short in relation to Mr Lewis and Mrs Peddie I can find absolutely no discernable evidence that I hold credible that they carried out any checking duties at all. Mrs Peddie concedes the point and the e mail documentation and the video evidence makes it perfectly clear Mr Lewis did very little checking. Insofar as Mr Lewis' word is relied upon that when he looked in the cells at 06:01 am my submission is that Mr Lewis' evidence is so untrustworthy that it cannot be relied upon as accurate evidence in any respect and certainly not enough to form an evidential platform in attempting to assess when Kristoffer Batt died.

I make reference briefly in respect of opiate recovery drug Narcolan. This was described as a wonder drug causing almost immediate recovery. No explanation took place as to the cost and administering difficulties by lay persons of this drug but assuming these were not impossibly difficult issues the provision of this drug and a system for its delivery should be in place or at least investigated.

Section 6(1)(d)

The Defect in the Systems which Contributed to the Death

The defects that came out in evidence were so obvious, so wide ranging and so frequent that presentation is easier with a short-listing of the main defects. I apologise for repetition.

- a) The Admission Form and Cell Checking Form requiring sensible amendment and coherently planned. This would enable special difficulties to be presented in more detail, giving warning to officers.
- b) Lack of historical information arising from the availability and accessibility to previous records
- c) Failure to devise, maintain and verify a standard admission procedure for custody officers
- d) Failure to appreciate the difference between persons attending voluntarily to enter custody and persons who have been arrested but have no time to plan for the secretion of drugs.
- e) Civilian turn keys failure duty to perform their prescribed duties.
- f) A culture whereby civilian staff can do what they like with impunity whether it be going to Tesco for shopping, read books or surf the internet.
- g) The lack of maintenance and checking alarm systems, ie, the buzzer system and the light activation system.
- h) The lack of responsibility for the CCTV Cameras to ensure the timing is accurate.
- i) The lack of monitoring by senior officers of the CCTV Cameras

- j) The lack of comparison checks done on the ADM 51(a) Forms with CCTV camera records.
- k) The lack of accountability or censure for senior officers for system defects and failure to apply systems.
- l) The lack of management of the custody suite.
- m) The lack of management structure for set responsibilities for recording system compliance, defect recording and the directing of responsibility for failure.
- n) The allowance by Senior Officers of an institutional culture of cell management, which is complacent.

Section 6(1)(e)

Any Other Facts which are the Relevant to the Circumstances of the Death

That every time there is a death in custody, police officers turn up and give evidence highlighting the defects, advising what steps are in hand to deal with this matter, usually after discussions with other police forces and they are never implemented by the time the next Fatal Accident Enquiry.

CONCLUSION

Had ADM19 Forms showing the history of Kristoffer Batt admissions to the custody sergeant on 28.11.07 were available, the custody sergeant would have taken more care in assessing the risks to Kristoffer Batt from injury by drug involvement, either

taken before initial admission or in the supervision of him in his individual cell after secretion on his person. It is reasonable to conclude that if the Custody Sergeant knew of the drug incidents recorded on previous custody admission forms he would have acted differently in authorising a search and perhaps more frequent inspection searches. In view of this comment and the earlier observations from another officer that there was a suspicion of Kristoffer Batt taking drugs, the Custody Sergeant should or would have instructed a full body search. A full search might have resulted in the finding of drugs or it may have altered the Custody Sergeant to a much stronger suspicion that Kristoffer Batt may be worth more extensive questioning and monitoring. More extensive questioning, referring to previous difficulties, standing the evidence of Kristoffer Batt being well mannered and a polite prisoner, might have resulted in an admission and production of drug contraband. If all a strip search had done was highlight a suspicion of drug taking, half hourly checks could and should have been ordered. If half hourly checks had taken place the possibilities of successful prevention or remedial action would have been exponentially increased.

This is not just a case of failure on the part of two persons namely Lewis and Peddie. This is a case of chronic institutional failures.

There was a chronic system of institutional failures, and in my submission while the conduct of the civilian turn keys was extra ordinarily culpable and unacceptable, this is set against a backdrop of a culture of indifference to risks to prisoners, system maintenance, training, complete absence of knowledge of senior officers of how the

custodial area was operating, and a complete indifference of senior officers willing to check that systems were adequate and being complied with.

Being emotive, how can an organisation with budgets of millions, with authority to take charge of persons in a way that deprives them of opportunity to look after themselves countenance a facility which does not check its prisoners. The supervisors do not check the checkers, safety systems such as the audible alarm and the red light system are either ignored or temporarily shut off for years at a time, apparently without anyone noticing. Video cameras are incorrectly timed and false data sheets prepared to the severe detriment of persons who by definition are restricted in their ability to fend for themselves. *Quis Custodiet Ipsos Custodes?*

APPENDIX 3C

SHERIFFDOM of TAYSIDE CENTRAL & FIFE at DUNDEE

SUBMISSIONS FOR STUART LEWIS

**in relation to the inquiry under Section 6(1)(a) of the Fatal Accidents and Sudden
Deaths Inquiry (Scotland) Act 1976**

**into the circumstances of the death of
KRISTOFFER BATT**

- 1 Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:-
- (a) where and when the death and any accident resulting in the death took place;
 - (b) the cause or causes of such death and any accident resulting in the death;
 - (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
 - (d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death; and
 - (e) any other facts which are relevant to the circumstances of the death.

2 **Determination**

I would invite the Sheriff to make the following determination:-

Section 6(1)(a)

That Mr Kristoffer Batt died on 28th November 2007 at some point between 0706 hours and 0746 hours within cell 11, Custody Area, Tayside Police Headquarters, Bell Street, Dundee.

Section 6(1)(b):-

That the cause of Kristoffer Batt's death was the adverse effects of heroin.

Section 6(1)(c):-

In relation to custody care assistant Stuart Lewis, there were no reasonable precautions that he could or should have taken which might have avoided Mr Batt's death.

Section 6(1)(d):-

That there were no defects in any system of working as operated by Stuart Lewis which contributed to Mr Batt's death.

Section 6(1)(e):-

That the following are facts in relation to the conduct on the part of Stuart Lewis which are relevant to the circumstances of the death of Mr Batt:-

- (a) Stuart Lewis' failure to deactivate Kristoffer Batt's cell light on attending his cell at 0601am.
- (b) Stuart Lewis' failure to notice before departing his shift at 0650am that Kristoffer Batt's light was on.
- (c) Stuart Lewis' failure to communicate with his female colleague that he was unsighted to the cell lights for large periods of time during his shift.

3 **Submissions for Stuart Lewis**

It is respectfully submitted:

1 **Time and Place**

It is difficult to be specific about the precise time of death in this case. Life was pronounced extinct at 0810 hours on 28th November 2007.

I would invite your Ladyship to accept the evidence of the custody care assistant, Alistair George Smith, that at 0706 hours that morning Kristoffer Batt was still alive. His evidence (transcript 11th May at pages 44-48) is that he attended Kristoffer Batt's cell at 0706 hours (he entered that time on the Admin 51a – production 10) and he opened the hatch and called through to Kristoffer Batt, shouting "Kris" three times. His evidence is that he "heard a grunt" which is recorded on the Admin 51a and also that he saw Kristoffer Batt change his position from lying on his back to moving onto his right hand side facing away from him (page 48). That Alistair Smith did shout through the hatch is supported by the custody care assistant, David Massie, who gave evidence that he heard his colleague shout to Kris while he was carrying out his own checks at that time (transcript 13th May, page 31). The CCTV footage confirms that Mr Smith was attending at Kristoffer Batt's cell hatch at that time.

Professor Pounder's evidence (transcript 5th May at page 142) is that if your Ladyship accepts the evidence that Kristoffer Batt grunted at 0706 hours then "he wasn't dead at that point in time. He may have been semi-conscious, that is a possibility, and therefore he may have been in the dying process, but he most certainly wasn't unconscious and wasn't dead, and that would mean that

he would have to have died between that moment and the moment when he was later discovered.”

The moment that Kristoffer Batt was discovered (again by reference to the Admin 51a, production 10) is 0736 hours when the witnesses, David Massie and Alistair Smith returned on the breakfast rounds to discover that they could not get a response from him. Mr Smith’s evidence on this (transcript 11th May) is that Kristoffer Batt was “warm and in good colour but never responsive”. David Massie’s evidence is (transcript 13th May, page 44) “There was never any sign of life. The whole time I was there, not once did I see any sign of life.”. When Sergeant Gregor Stewart attended he could find no pulse.

This is consistent with the evidence from Bruce Rungay, the paramedic who attended (transcript 2nd June 2009). Bruce Rungay’s evidence is that he received the call at 0738 hours and he arrived at the cell at 0746 (page 15). His evidence is that Kristoffer Batt was unconscious and unresponsive and that there were no signs of life. At page 42 he stated “I would say he (Kristoffer Batt) would have been in that condition for within 15 minutes”. He added that in his opinion, his findings were consistent with death having occurred, based on all of his experience, at between 10 and 15 minutes before, ie. between 0731 and 0736am.

Professor Pounder stated (transcript 5th May, page 112) “that the person was dead during some of the resuscitation efforts. It may have been all, it may not have been all.” This was supported by his finding of parchmented red marks on the front of the chest and front of the neck due to resuscitation efforts.

There was no underlying bruising beneath these marks indicating that they were not produced by trauma in life. (Page 111, transcript 5th May.)

The evidence from Alistair Smith, David Massie, Gregor Stewart, Bruce Rumgay and Professor Pounder, taken together, indicates that death most likely occurred at some point between 0706 and 0746 hours. Despite the faultless and professional efforts by the paramedics, and those in attendance, death had probably occurred a few minutes before 0746am.

In terms of where and when “any accident resulting in the death took place”, the overwhelming evidence is that Kristoffer Batt ingested heroin (that he had secreted about his person) by means of “tooters” that he had fashioned by ripping up pieces of cardboard from the toilet tissue box within his cell at some point between his arrival in the cell at 0412 and his discovery by Alistair Smith and David Massie at 0736 hours. There is no direct evidence about when the ingestion of the heroin took place and the best and only evidence about the timing of the taking of the heroin comes from Professor Pounder.

Professor Pounder explained (transcript 5th May, page 120) that the presence of a substance known as 6-MAM in post-mortem urine but not in blood, indicated that Kristoffer Batt is likely to have died at least twenty minutes after taking heroin and possibly more than an hour after.

Professor Pounder indicated that it was very difficult to attach probabilities to these events and what he said was (at pages 120-121) “In the usual course of events, if someone dies very rapidly after the use of heroin, then the heroin would be converted to 6-MAM, but the 6-MAM won't have disappeared and we can detect it, so we regard it as indicator of an early dirty death following

the use of heroin, and what constitutes early, obviously, there is a grey zone, but almost certainly within an hour, more likely than not within twenty minutes, although sometimes, but very rarely, we detect the 6-MAM after two hours so, on balance, this is quite a short survival period after having used the heroin.”

Professor Pounder went on (page 122) to elaborate that in his opinion, given that the 6-MAM was not found in the blood, he must have survived at least twenty minutes after taking it but the most he could say was “... in fairness, one would say he’d probably must have survived an hour, but how much longer, again, couldn’t really say”.

2 Cause of Death

The post-mortem examination report (production 4) narrates the cause of death as “adverse effects of heroin and Diazepam whilst in police custody”.

Professor Pounder’s evidence (transcript 5th May, pages 116-117) is that the deceased used Diazepam or Valium, perhaps late on the evening before he handed himself in or in the early hours of that morning. (This is supported by the toxicology analysis which revealed the presence of Diazepam, 0.4mg per litres and its metabolite with no Diazepam in post-mortem blood.)

Professor Pounder went on (transcript 5th May, page 125) “I would say that the focus should be on the heroin as the cause of death, and not so much on the Diazepam, although we recognise that the Diazepam generally increases the risk but that is a statistical effect, if you like, and we can’t tease out that in relation to any individual case.”.

The post-mortem report states:- “Morphine, (derived from heroin), as indicated by the presence of 6-MAM, was detected in the post-mortem at a level of 0.11mg per litre. The level of morphine reported in heroin fatalities ranges from 0.01 to 3.0mg per litre.”

Professor Pounder explained that there are reported fatalities at the range of morphine that was found within Kristoffer Batt’s system and so his system had a (page 118) potentially fatal level and the determination of its fatal level is really by the exclusion of other causes. He said “and we have not found any natural disease. We have not found any trauma. This is the only thing that we have that can potentially cause death, therefore the reasonable link is that it has caused death.”.

This is supported by the evidence of Kristoffer Batt having fashioned tooters out of ripped up pieces of cardboard from the toilet tissue box provided in the cell – Sergeant Gregor Stewart (transcript 12th May, page 48) found “tooters”.

3 Precautions

Were there any reasonable precautions that Stuart Lewis ought to have taken that might have avoided Mr Batt’s death in terms of Section 6(1)(c) of the 1976 Act?

Insofar as reasonable precautions are concerned, it is accepted that the test is not whether or not there is a reasonable precaution whereby the death or accident resulting in a death “would” have been avoided but only where it “might” have been avoided so what is envisaged by the Act is a real possibility that the death might have been avoided by a reasonable

precaution on the part of Stuart Lewis. It is respectfully submitted, however, that there must be a causal connection between any failure to take a reasonable precaution and Kristoffer Batt's death. Reference is made to Carmichael Sudden Deaths and Fatal Accident Inquiries, 3rd Edition, paragraph 5-77.

Stuart Lewis' first contact with Kristoffer Batt on 28th November was when he was being lodged in his cell by the custody sergeant, Sergeant Alan Kidd. It was Sergeant Kidd's responsibility to assess the status of Kristoffer Batt. It was his decision not to strip search Kristoffer Batt. His assessment was that Kristoffer Batt was a low vulnerability prisoner and therefore should be subject to hourly checks by a custody care assistant on duty. For low vulnerability prisoners on an hourly check regime, especially through the night, the evidence before the inquiry is that no verbal response was required from them.

(For the avoidance of doubt, it should be noted that no criticism is levied on behalf of Stuart Lewis at Sergeant Kidd in relation to his assessment of Kristoffer Batt's level of vulnerability.)

In addition to hourly checks, it was the custody care assistants' duty to respond to the cell lights within a reasonable period of their being illuminated. At that time the cell light was the only official means that custodies had of alerting the custody care assistants to a request for assistance. There was a buzzer system in place but inexplicably all the buzzers in the adult cells had been muted a few years previously but no-one knew exactly when. Stuart

Lewis' evidence was that they had never worked during his time there, which had commenced in 2003. The fact that the buzzers had all been muted is, in my submission, a management failure and not one for which Stuart Lewis can be held to account. The calls could be for a variety of reasons, from requiring an extra blanket, or a cup of water, to finding out what the time was or to ask to see a doctor. The only way the custody care assistant could know what the custody required was by answering the cell light.

There did not appear to be a set time for the period within which a light should be answered but the general consensus of the witnesses, and the general understanding of the custody care assistants, including Mr Lewis, was that if a light had been illuminated by a custody whose status was high vulnerability, then it should be responded to immediately or as soon as possible. Where the status of the custody was low vulnerability, then the light should be responded to within a period of five or ten minutes. There was some evidence that fifteen minutes would be alright if there was a good explanation as to why it couldn't be responded to earlier (Gregor Stewart, 12th May). For example, if a custody care assistant had been involved in another legitimate task that took him outwith the cell area. For any period greater than fifteen minutes, there would have to be a very good explanation indeed and no-one (including Stuart Lewis) accepted that as a matter of generality, a failure to respond to a cell light after fifteen minutes was acceptable.

The evidence before this inquiry, from the CCTV footage and analysis, is that for two periods during Stuart Lewis' shift, Kristoffer Batt's cell light remained illuminated for an unacceptable length of time. The first of these was approximately 49 minutes and the second was approximately one hour and

twenty minutes. There is no excuse for that. We now know that for large parts of his shift that evening, Stuart Lewis was unsighted to the lights because he was in the fingerprint room accessing the internet. There were no cell lights in the fingerprint room. There is also evidence of Stuart Lewis carrying out work related tasks, including escorting a new prisoner to his cell at approximately 0500am and releasing two prisoners between approximately 0532 and 0544am. There is no evidence that Stuart Lewis was on the internet after 0618am.

In relation to the first failure to respond to Kristoffer Batt's light, it is respectfully submitted that even had Stuart Lewis responded to the light within the proper timeframe, ie. up to fifteen minutes, there is no evidence that that would have had any bearing on Kristoffer Batt's death. I would ask your Ladyship to accept the evidence that when that light was responded to at approximately 0510am, Stuart Lewis dropped the hatch of Kristoffer Batt's cell and spoke with him. He passed through an extra blanket and fetched a cup of water for him, which he also passed through the hatch. This is all supported by the CCTV evidence which shows him carrying out those tasks and shows him having completed an entry on Kristoffer Batt's Admin 51 form, which entry is recorded as "watered". [It is not possible to be certain about the real time as the CCTV clocks were running between 10-20 minutes slower than real time and it is simply not known whether the different cameras analysed were out by different amounts of time or the same amounts of time or whether any differential varied between the cameras over the period with which this inquiry is concerned.]

Stuart Lewis' evidence was that he spoke to Kristoffer Batt who had mentioned a tattoo that he had recently had done on his neck and wondered whether he might be able to get Vaseline for it, to which Stuart Lewis had said that he could go and ask the Sergeant to get a nurse but he didn't think that it was likely that the sergeant would get a nurse for that, and so Kristoffer Batt had decided not to bother about it (transcript 14th May 2009, pages 56-57).

Stuart Lewis engaged with Kristoffer Batt about an hour after he had been placed in his cell and Stuart Lewis' evidence is that there was nothing at all about Kristoffer Batt's demeanour at that time which gave him any cause for concern. Stuart Lewis had seen Kristoffer Batt when Sergeant Kidd was placing him in the cell approximately one hour before that and both Sergeant Kidd and Stuart Lewis' evidence on Kristoffer Batt's demeanour at that point, ie. when he was placed in the cell, was that there was no cause for concern and that he was in relatively good humour and chatty and coherent.

Kristoffer Batt's cell light was activated by him for the second time at approximately 0545am real time. Stuart Lewis attended at his cell at 0601am - a period slightly, but not excessively, outwith the expected time for responding to the cell light of a low vulnerability custody.

According to Stuart Lewis, Kristoffer Batt was alive and well at this point. Thereafter Kristoffer Batt's cell light remained illuminated until it was switched off about an hour later by the next shift. Stuart Lewis went off shift at approximately 0650am, so he failed to notice that Kristoffer Batt's light was still illuminated for a further period of 49 minutes. When the next shift arrived,

they attended Kristoffer Batt's cell within 15 minutes of coming on shift, satisfied themselves that he was okay against the background that they did not require a verbal response from him and they do not expect much of a response from custodies at that time of the morning (transcript 11th May, per Alistair Smith at page 15). Alistair Smith heard Kristoffer Batt grunt and saw him turn over. He then switched off the cell light. Accordingly, Stuart Lewis' failure to notice that he hadn't switched off the light, while lamentable, cannot be said to be causally connected to the death.

It must also be noted that Stuart Lewis was not the only custody care assistant on duty on the 11pm-7am shift that night with the responsibility to answer Kristoffer Batt's cell light. Linda Peddie was covering the same shift and insofar as the period 0601 to 0650am is concerned, the evidence is that she was, for the most part, situated in the custody care assistants' office which contained a panel of all the cell lights and to which she ought to have been having regard.

Immediately following Kristoffer Batt's death, officers from Fife Police took over the investigation into the circumstances surrounding the death. During those investigations they seized the CCTV footage and scrutinised it. As a result of that scrutiny, they found that Stuart Lewis had not been carrying out his duties properly. On the 11pm to 7am shift on 27th/28th November 2007, he had not carried out checks on some of the cells, that is cells 9, 10 and 15. Not only that, he falsified entries. Scrutiny of the CCTV evidence also revealed the fact that Stuart Lewis had not responded to the cell light at Kristoffer Batt's cell timeously on two occasions and that when he did attend Kristoffer Batt's cell at 0601am he omitted to deactivate the light, thus

rendering that means of communication by Kristoffer Batt thereafter useless until it had been re-set by the oncoming shift at 0706am.

As a result of these findings, Stuart Lewis faced a criminal investigation and disciplinary proceedings. When he eventually came to the witness box in this inquiry he was already potentially in a very difficult position regarding his credibility. It should be said that having gone through these other procedures and never having appeared in court before (unlike most of the other witnesses at the inquiry) Stuart Lewis found the proceedings immensely stressful. He was extremely nervous while giving his evidence and as a result did not present well.

Mr Boyle for the family of Kristoffer Batt posed the question in terms "Why should Stuart Lewis be believed about what he saw at Kristoffer Batt's cell at 0601am when there is so much evidence about failures in duty on his part in the course of that night, including the very serious matter of having falsified records?".

There is absolutely no evidence which can contradict Stuart Lewis' account of what he saw when he looked in Kristoffer Batt's cell at 0601am. His evidence is not inconsistent with the CCTV evidence of this visit. For whatever reason, Stuart Lewis allowed himself to be distracted from his role on that night and for a large part of the time simply wasn't paying attention to the lights as he should have been and carrying out his checks as he should have been, although it must be stressed that the irrefutable evidence insofar as Kristoffer Batt is concerned is that Stuart Lewis did carry out hourly checks. We do not

have to rely on Stuart Lewis' word for that but we can see him doing this on the CCTV on two occasions at hourly intervals after his initial contact with Kristoffer Batt at 0412am. There was a concern at the outset of the inquiry that Stuart Lewis' own watch was not at the right time but there was no evidence to support that and indeed the times entered on the Admin 51a do accord with the real time when one allows for the discrepancy of time in the CCTV footage which was largely accepted as being about 16 minutes out, although the spectrum for the fault, depending on the camera, was put at 10-20 minutes by Lee Dickson who headed up the Fife Constabulary Investigation (transcript 10th June).

In the course of his examination in chief, the Fiscal very fairly put to Stuart Lewis that all the entries that he had made in relation to the falsified entries for the Admin 51a for cells 9, 10 and 15 read the same, whereas his entry for 0601am states "sitting up okay". I would concur with the Fiscal that it is more likely than not that had Stuart Lewis been making up that entry, he would probably have recorded the same as for the other made up entries.

We know that Stuart Lewis looked into Kristoffer Batt's cell for a good seventeen seconds. We see that on the footage.

His account of what he saw is as follows (transcript 15th May, pages 28-32)
"Just that he was sitting up. He had his feet on the floor. He had one hand on his knee and he was generally sitting up, straight back, not slouched. He gave me no cause for concern... at one point he picked his foot off the floor, looked at his foot, put it down".

The CCTV evidence also confirms that after Stuart Lewis has looked into Kristoffer Batt's cell for seventeen seconds, he went back very shortly afterwards to have another look in the cell (for seven seconds). His evidence is that he didn't see anything suspicious and, if he had, he would have intervened.

Why should we believe Stuart Lewis on that? None of the police officers who gave evidence at this inquiry would seek to excuse the delay in responding to Kristoffer Batt's cell light but all of those who were asked certainly expressed surprise that Stuart Lewis behaved in the way that he did that night and felt that that was not characteristic of his usual behaviour. There was some evidence of dip sampling audit of the custody care assistants' work by the sergeants and Sergeant Kidd's evidence was that he did go down and check that the custody care assistants were carrying out their checks during every shift and, in addition, he would audit his staff once or twice a month via the CCTV monitors (transcript 8th May, page 29).

Sergeant Alan Kidd (transcript 8th May, page 13) was asked in cross-examination what his impression of Stuart Lewis' level of competence was as a custody care assistant and his response was "I rate him one of the best custody, male custody care assistants, that we had" and (at page 14) "I found him conscientious, alert and I thought he did his job particularly well and I made various comments in the time that I had him as my CCA to that effect".

He went on to say (page 16) that he was satisfied that if Stuart Lewis had seen anything untoward going on in Kristoffer Batt's cell, he was confident that he (Stuart Lewis) would have acted to intervene.

This is not simply the statement of a line manager trying to support one of his members of staff.

The reason why Sergeant Kidd felt confident is that he had previous experience of Stuart Lewis doing just that, ie. seeing something untoward going on in a cell and intervening. Reference is made to production number 1 for Stuart Lewis, containing two performance reviews.

The performance review notes which were completed by Sergeant Kidd state:- "During night-shift on 23rd February 2006, a named male, who was in custody and within the observation cell, due to concerns for his mental health and possible suicidal tendencies, at one point during the shift and whilst working alone in the cell area, CCA, Stuart Lewis, came across a male almost in a state of unconsciousness, having ripped a piece of blanket and placed it round his neck in an attempt to strangle himself. CCA Lewis immediately entered the cell, removing the cord from around the male's neck, placing him in the recovery position, before alerting others to the situation. The male very quickly came round and was none the worse for the attempt on his life. It is quite apparent that it was only through the alertness and the action of CCA Lewis that this male did not suffer any lasting injury or indeed hang himself in his cell. He is to be commended for his actions."

The second review note states:- “During the weekend of 23rd March 2007, through to 25th March 2007, the custody suite had one of its busiest weekends for some considerable time. Throughout that night-shift and your (Stuart Lewis) time on duty, you performed well and showed that that shift worked well as a team. I thank you for this and your continued support in the custody suite.”.

Although these were the only performance reviews produced at the inquiry, Sergeant Kidd went on to say that there were other examples that he could recall where Stuart Lewis had alerted him to someone’s vulnerability changing and he had called for him to come down and have a look at the vulnerability status. Sometimes he had changed the status, sometimes he had not.

Against that background, to suggest that because Stuart Lewis has been shown to have failed in many aspects of carrying out his routine job on the night of Kristoffer Batt’s death, he could therefore have stood and watched something untoward happening in Kristoffer Batt’s cell and not done anything about it is, in my respectful submission, unsustainable, both logically and on an evidential basis.

Stuart Lewis could offer no explanation as to why when he attended Kristoffer Batt’s cell at 0601am he did not simply drop the hatch and speak to Kristoffer Batt. His evidence was that he was attending to Kristoffer Batt because he was due an hourly check and certainly the timings of that would tend to support that evidence. As the red light was on, he should have asked Kristoffer Batt if he wanted any assistance and he could have done that

because Mr Batt was sitting up and awake but what is it we are expecting Kristoffer Batt to tell Stuart Lewis? In my respectful submission, it is highly unlikely that Kristoffer Batt had any intention of letting the custody care assistant know either that he intended to take heroin or that he had just taken heroin. In my submission, it is more likely, given the timings spoken to by Professor Pounder (see 2 above) that Kristoffer Batt had not yet taken the heroin at the point where Stuart Lewis saw him at 0601am and, in that connection, I would refer to the evidence of Professor Pounder in response to Mr Boyle's cross examination about whether there should be a panic bell for custodies to use in circumstances where they had taken heroin.

Professor Pounder accepted that someone having taken heroin might have time to press a panic button but his evidence was that he didn't think that they would. He stated as follows:- (transcript 5th May, page 149)

"I don't know that they would, in that the loss, loss of consciousness as a result of heroin use and, if you like, a near miss death, is relatively common among heroin users, and most abusers would have either have experienced it or would have been with someone who had experienced it, and they would have probably taken no action. They would have probably waited, and waited to see what had happened. The reason being that if they seek medical attention, they will be given Narcan and that counteracts the effect of the heroin so, for a heroin abuser, that's, if you like, a disincentive to ask for assistance, so that's the problem. Someone might not ask for assistance..."

Professor Pounder stated under cross examination at page 152 "Depending upon his experience of the use of heroin, he may either have experienced that before, or seen somebody experience it before, and therefore not have a particular concern about it, if you like, or any concern will be counterbalanced by the desire to retain the effect of the heroin."

It is therefore my respectful submission that even had Stuart Lewis engaged in conversation with Kristoffer Batt at that time, it is unlikely that he would have gleaned anything about his intended heroin use.

We know that Stuart Lewis omitted to deactivate the cell light after checking Kristoffer Batt at 0601am. The light therefore remained on for another hour and five minutes until it was deactivated by custody care assistant Alistair Smith. We have no way of knowing, and can never know, whether Kristoffer Batt attempted to use his cell light to attract the attention of a custody care assistant after 0601am but in vain. There was evidence from various witnesses that if a custody wants to attract the attention of the custody care assistant they can shout or bang on the cell wall or door and that is a fairly frequent occurrence. Against that it was suggested by the Fiscal and Mr Boyle that if the custody had fallen ill then he or she may not be in a position to call out or bang on the cell door or wall.

There is no evidence that Kristoffer Batt was desperately trying to attract the attention of the custody care assistant and it is my respectful submission that it is more likely than not that Kristoffer Batt may not have appreciated that he

was in need of assistance and even if he had, he may have been reluctant to call for it.

Kristoffer Batt was found lying on the raised platform in his cell with his blanket around him.

Professor Pounder (transcript 5th May , page 127) explained the way in which heroin acts on the body “we would expect the person to lose consciousness. That might be gradual or rapid. It depends on the particular circumstances of the case. They might, for example, be semi-conscious for a period of time, as I say if they had passed out, you could rouse them. That would pass into unconsciousness before death. The drug depresses the breathing and so a period in which the breathing was abnormal would usually be noted.”.

Page 151, under cross-examination, Professor Pounder stated:- “It is certainly true, that it is more likely that he (Kristoffer Batt) would fade into unconsciousness.

3 **Defects in any System of Working as Operated by Stuart Lewis**

For a finding under this section, it is submitted that there must be a causal connection between any defect in any system of working as operated by Stuart Lewis and Kristoffer Batt's death. It is respectfully submitted that while there were shortcomings in the way in which Stuart Lewis carried out his duties that night, there is no evidence to support a finding that his failures were causally connected to Kristoffer Batt's death.

Kristoffer Batt was still alive at 0706am.

Stuart Lewis' failure to respond timeously to Kristoffer Batt's cell light is a defect in the system of working as operated by Stuart Lewis but again it is respectfully submitted that this defect, this failure, was not causally connected to Kristoffer Batt's death. Stuart Lewis' evidence about what he saw on attending Kristoffer Batt's cell on the three occasions that he did throughout his shift, is that Kristoffer Batt appeared alive and well and gave him no cause for concern.

In this connection, it must be borne in mind that it is only with the benefit of hindsight and having access to the information that we have had in relation to the preparation for this inquiry, that we know the detail of Kristoffer Batt's chaotic lifestyle. (His medical and custody records, and evidence of Sean Smart.) Stuart Lewis didn't know about Kristoffer Batt's history of drug abuse. When he checked Kristoffer Batt, he was checking a custody who had been assessed as low vulnerability with whom he had engaged and had no cause for concern. He had no reason to doubt the Sergeant's assessment. He didn't know that Kristoffer Batt was a drug user and so when he did check Kristoffer Batt, he wasn't checking someone who he thought was in a bad way due to drug misuse, he wasn't checking someone who he expected not to be okay. That observation is equally apposite in relation to Alistair Smith's check at 0706am.

Stuart Lewis should have deactivated Kristoffer Batt's cell light after he checked him at 0601am but there is no evidence that his failure to do this contributed to Kristoffer Batt's death and given Professor Pounder's evidence on the mechanism of death from heroin abuse, it seems unlikely that Kristoffer Batt would have been seeking assistance in relation to his having taken heroin for two reasons:- Firstly, because he may not have

been aware that he needed assistance and, secondly, he would not have wished to have been administered Narcan.

We know from the evidence of Alistair Smith, David Massie and Professor Pounder that Kristoffer Batt was alive at 0706am, albeit that he may have been slipping into unconsciousness at that point.

Had the buzzers been working, then we might have had a better idea about whether or not Kristoffer Batt did seek assistance after 0601am because he would have had to physically be at the cell door to press the buzzer and keep pressing it to keep it sounding. Moreover the noise of a buzzer would be far more likely to prompt action by Linda Peddie who would/should have heard it in the custody care assistants' office. Of course, for any period that Stuart Lewis was in the fingerprint room or kitchen or upstairs the buzzers were not in any event designed to sound in those places and so he may not have heard them. As indicated at 2 above, however, the failure of the buzzer system was not an individual failure but a management one.

4 **Facts relevant to the circumstances of Kristoffer Batt's death** (S6(1)(e))

It is accepted that the custody care assistants' primary function is the care and welfare of the custodies. Inspector Gary Brown. (Transcript 3rd June, page 212) stated:- "Their job is to be checking prisoners."; and

(Transcript 3rd June, page 214) "Custody care assistants look after prisoners. That is their job."

One of the most fundamental aspects of that job is to answer cell lights timeously.

Stuart Lewis put himself in the position where, for a large part of his shift on 28th November, he was unsighted to the cell lights and had no way of knowing whether Kristoffer Batt was seeking assistance or not. The fact that he was on the internet is neither here nor there. The point is that whatever he was doing, he was not checking the lights as he should have been. There is no excuse. However, there was no evidence, in my submission, to the effect that there was an adverse result in respect of this failure.

As a result of Stuart Lewis' failure to deactivate Kristoffer Batt's cell light at 0601am, Kristoffer Batt had no other means of getting the attention of the custody care assistants, other than shouting or banging on the cell wall, which he might not have been in a position to do due to the effect of the drugs he had taken. The very sad aspect of this failure is that given the length of time it took Stuart Lewis to answer Kristoffer Batt's cell lights that night and given the fact that his colleague, Linda Peddie, made no attempt to answer Kristoffer Batt's light whatsoever there is no guarantee that a newly illuminated cell light would have been responded to any more timeously.

Had Stuart Lewis been paying attention to his job and checking the cell lights properly then, albeit that he had attended at 0601am, he should have noticed that Kristoffer Batt's light was illuminated and gone back to check on him. Again, in my submission, there was no evidence of an adverse effect in respect of such failure.

The fact that there was a lack of communication between Stuart Lewis and his female colleague on duty that night, Linda Peddie, highlights a supervision and training issue which is relevant to the circumstances of Kristoffer Batt's death. Stuart Lewis failed to

communicate to Linda Peddie that he was unsighted to the cell lights for large periods of time during his shift. Some of the time this was because he was carrying out other tasks, for example, releasing prisoners or preparing a particular prisoner who had been detained for attempted murder in a particular way. Stuart Lewis made an assumption that if he was releasing prisoners he would have to walk past the custody care assistants' office where Linda Peddie was stationed and so she would see that he would be leaving the cell area because he would have to go up to the main office to release the prisoners but he should have told her. Without attempting to excuse Stuart Lewis, if Linda Peddie had been doing her job properly, then she would have noticed that Kristoffer Batt's red light was being illuminated for large periods of time without being answered. She was under a duty to respond to all cell lights, not just the female ones - a duty which she eventually reluctantly accepted was hers. Stuart Lewis and Linda Peddie had assumed roles that were gender based. They simply assumed that unless their colleague specifically requested assistance from them, they were to deal with custodies of their sex only. It was clear that that was generally what their practice was.

Senior police officers gave evidence to the effect that it was common sense that both the female and the male custody care assistants had responsibility to answer the lights whether it was for female cells or male cells. They thought that it was common sense that each custody care assistant should tell the other if they were going to be leaving the cell suite. They wrongly assumed that the custody care assistants didn't require that to be spelt out to them.

Chief Inspector Lorna Robbie, (transcript 4th June, pages 139 and 149) stated: "I would expect them to work together" and "I would have expected it was reasonable for both of them to communicate with each other."

There was evidence from Sergeant Kidd and Inspector Gary Brown that the CCAs did, to their knowledge, generally work as a team but the inescapable evidence in relation to the night shift of 27/28 November 2002 is that not only did they not work as a team but as individuals they failed to deliver the standard of care reasonably expected of them in their role as CCAs albeit that that failure was not in my submission causally connected to Kristoffer Batt's death.

There was no evidence as to the training that Stuart Lewis had received initially on taking up the post of custody care assistant but generally the evidence was of new custody care assistants shadowing more experienced ones. It has never been Stuart Lewis' position that he didn't know what his job was. However, in an environment where the welfare of the most vulnerable of society is entrusted to custody care assistants, it is imperative that the custody care assistants receive ongoing training and reinforcement of the most basic requirements of their job, even if these requirements seem obvious to their line managers.

APPENDIX 3D

FATAL ACCIDENT INQUIRY

DEATH OF KRISTOFFER BATT

SUBMISSIONS FOR THE CHIEF CONSTABLE

THE FATAL ACCIDENT AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

Section 6(1)(a)

Where and when the death and any accident resulting in the death took place.

It is submitted that the death took place in cell 11 at Tayside Police Headquarters, West Bell Street, Dundee.

Death occurred on 28 November 2007 at some point after 07:06. Bruce Rumgay, Ambulance Service Paramedic attended with his colleague arriving at Police Headquarters at 07:46.38 (CP 28 and 02/06/09 p. 11). He and his colleague provided emergency treatment.

Their efforts were unsuccessful. They pronounced life extinct at 08:10 on 28/11/07 (**CP 14 and 02/06/09 ps. 33 and 34**).

Any accident, or perhaps more properly, incident, commenced at some point on 27 November 2007 when Kristoffer Batt may have taken drugs (**14/05/09 ps. 20 to 29**) and continued into 28 November 2007 when he was in possession of drugs (**14/05/09 ps. 33-38**) which he subsequently consumed.

Section 6(1)(b)

The cause or causes of the death and any accident resulting in the death.

The starting point was the taking of a variety of drugs by Kristoffer Batt. The evidence demonstrated that he had in the past abused drugs probably including ecstasy, cannabis, valium and heroin.

On the basis of the post mortem report (**CP 4**) and the toxicology report (**CP 5**) Professor Derrick Pounder and colleague Doctor Elizabeth Lim found the cause of death to be “adverse affects of heroin and Diazepam whilst in police custody”. This conclusion was spoken to in evidence by Professor Pounder (**05/05/09 p. 124**).

THE OTHER SUB-SECTIONS OF THE 1976 ACT

As often occurs in Fatal Accident Inquiries, there can be an overlap, or potential overlap, between three sub-sections, namely:-

Section 6(1)(c)

The reasonable precautions, if any, whereby the death and any accident resulting in the death, might have been avoided.

Section 6(1)(d)

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

Section 6(1)(e)

Any other facts which are relevant to the circumstances of the death.

The following is relevant to these 3 Sub-sections:

THE EVENTS & THE EVIDENCE

Chronology

The sequence of events on the evening of the 27 November 2007 is not clear. On the basis of the evidence of Sean Smart, Mr. Batt may have taken drugs at some point that particular evening.

What is clear is that Mr. Batt intended to “hand himself in” before 04:00 at West Bell Street in respect of an outstanding warrant. Arrival and “handing in” before 04:00 was understood to ensure that a person would appear in Court that morning and would not be detained for a further overnight.

According to Sean Smart, Mr. Batt arrived at Mr. Smart’s house at around 02:00 **(14/05/09 ps. 12 and 13)**. Mr. Smart’s evidence as to whether or not he thought Mr. Batt had taken drugs prior to his arrival was not entirely clear and not entirely in line with the statement he had originally provided to Tayside Police **(14/05/09 ps. 21 to 27)**.

Mr. Batt and Mr. Smart went to West Bell Street so that Mr. Batt could hand himself in before 04:00. Mr. Batt had in his possession cannabis and heroin which he apparently intended to use once he was “inside”. **(14/05/09 ps. 33 to 38)**

CCTV coverage shows Mr. Batt and Mr. Smart walking into the car park at West Bell Street on approach to the Police Office. On the basis of the CCTV analysis **(CP 16)** the time was around 03:51.

Mr. Batt attended at the Police Office. He explained why he was there initially speaking to PC James Mitchell then to PC Lindsay Dow **(08/05/09 p 109)**.

While his details were being checked Mr. Batt and Mr. Smart along with another person attending, Bruce Mills, went outside the building.

There according to Mr. Smart he and Mr. Batt smoked a joint of cannabis **(14/05/09 ps. 46 to 50)** which Mr. Batt had probably taken from between his buttocks and ultimately replaced there. What can be seen from the CCTV footage appears to be in line with Mr. Smart's evidence on this point.

In the Public Office three standard forms were partially completed by Lindsay Dow, ADM 51 **(CP9)** ADM 51 (a) often referred to as the cell sheet **(CP10)** and a Risk Form ADM 19 **(CP11)**.

Computer checks for risk markers were carried out by the civilian public enquiry officer Gillian Kennedy **(08/05/09 p 111)** and entered by Lindsay Dow **(08/05/09 p 112)**. Lindsay Dow also entered on the ADM 51 "appears under influence of drink or drugs on arrest". **(08/05/09 ps 112 and 113)**.

Lindsay Dow took Mr. Batt from the public enquiry area through to the Charge Bar where the Custody Sergeant was Sergeant Alan Kidd.

Sergeant Kidd assessed Mr. Batt and completed the ADM 51. On the basis of his assessment he changed his original intention to strip search Mr. Batt and decided that such a search was not necessary.

He assessed Mr. Batt as Low Vulnerability deciding that hourly checks were appropriate (see below).

Sergeant Kidd was unaware of any previous drugs history **(08/05/09 ps 37 and 38)**.

Mr. Batt was searched by Sergeant Kidd himself who found nothing of any note on that search **(08/05/09 ps 64 and 65)**.

The Charge Bar Procedure was recorded on CCTV and available to the Inquiry.

Sergeant Kidd took Mr. Batt from the Charge Bar area down to the cells. He placed him in cell 11 having taken the 3 forms, ADM 51, ADM 51 (a) and ADM 19 down to cell 11 with him. **(08/05/09 p 58)**. The entry made by Sergeant Kidd on ADM 51 (a), shows Mr. Batt was placed in cell 11 at 04:12.

The cells were equipped with a red light warning system (and indeed a buzzer system, see below).

Using the CCTV Analysis **(CP 16)** the red light outside cell 11 is illuminated at a CCTV time of 04:10.32.

Due to CCTV time slippage (see below) the necessary correction was considered to require the addition of anything from 16 to 18 minutes to CCTV time to arrive at the actual time. It is suggested however that it is far from clear whether or not 16 to 18 minutes is the correct add on or indeed if different cameras require a different add on.

In any event there is a response by the Custody Care Assistant Stuart Lewis about 49 minutes later, CCTV time 04:59.13. On the basis of the CCTV footage Mr. Lewis looks into cell 11 through the spy hole in the door, then opens the door hatch and hands through a blanket. The red light is switched off by Mr. Lewis pressing a switch on the corridor wall alongside the cell door. Mr. Lewis takes a cup of water and passes this through the hatch at cell 11. After closing the hatch he writes on the cell sheet. This would appear to match with an entry on the ADM 51 (a) at 05:10 which says “watered”.

At a CCTV time of 05:10.03 Mr. Lewis is seen in the cell passageway where cells 9, 10, 11 and 15 are occupied. According to the CCTV Mr. Lewis marks the cell sheets for cells 9, 10, and 15. It is a matter of individual interpretation whether or not it is considered the CCTV shows Mr. Lewis passing by the cells without actually looking into them. Mr. Lewis at various points in his evidence maintained that he had looked in (eg. **07/05/09 ps 138 to 142**).

At CCTV time 05:25.13 the red light again appears at cell 11. At a CCTV time of 05:42.46 Mr. Lewis can be seen looking in cell 11 through the spy hole for 17 seconds. He is then shown writing on one of the forms presumably the ADM 51 (a) and looks into the cell again.

An examination of ADM 51 (a) itself shows an entry for 06:01 “sitting up- is ok”.

At the time of this particular check the CCTV shows that the red light at cell 11 was not switched off.

A new shift was due to take over at 07:00 and at a CCTV time of 06:48.05 the red light at cell 11 was switched off by Custody Care Assistant Alistair Smith. In evidence Mr. Lewis accepted that the red light outside cell 11 had been on for a period of in excess of one hour **(14/05/09 p 148)**.

With a new shift due to commence at 07:00 there was a handover in advance with the oncoming Custody Sergeant, Sergeant Gregor Stewart receiving a briefing from Sergeant Kidd and a Custody Handover Form **(CP 13)** being completed.

There was a handover from the nightshift Custody Care Assistants Stewart Lewis and Linda Peddie to the oncoming Custody Care Assistants Alistair Smith and David Massie.

On the CCTV and at an analysis time of 06:47.26 Mr. Smith enters the passageway which includes cell 11. At 06:48.05 he switches off the red light at cell 11 opens the hatch, looks in and writes on the cell sheet. He looks in again at 06:48.47.

Consideration of the ADM 51 (a) shows an entry at 07:06 “grunted”.

In evidence Mr. Smith spoke to this entry **(11/05/09 p 47)** and also spoke to a movement from Mr. Batt in that he changed from lying on his back to lying on his right hand side **(11/05/09 p 47 and 48)**.

The CCTV as supported by the analysis shows Messrs Smith and Massie enter the passageway which included cell 11 at a CCTV time of 07:18.41. They were clearly handing out breakfasts. The procedure is outlined in evidence by Mr. Smith **(11/05/09 p 54 to 56)**.

ADM 51 (a) has an entry which Mr. Smith confirmed he made at 07:36 to the effect “prisoner not responding. Custody sergeant informed.” **(11/05/09 ps 58 and 60)**.

Having obtained no response both Mr. Massie and Mr. Smith entered cell 11 **(11/05/09 p 63)**. Mr. Smith shook Mr. Batt’s left shoulder and saw what he thought looked like “a lot of white like sick around his mouth”. **(11/05/09 p 66)**.

Mr. Smith goes on to give evidence about the steps taken to try and revive Mr. Batt until the arrival of the paramedics **(11/05/09 p 68 to 77)**.

Paramedic Bruce Rungay and his colleague provided emergency treatment. This treatment was to no effect and life was pronounced extinct at 08:10 on 28 November 2007. **(CP 14 and 02/06/09 ps 33 and 34)**.

AREAS FOR CONSIDERATION

The Death and Causation

Irrespective of the inexcusable failings on the part of the Custody Care Assistant Stuart Lewis the evidence, it is submitted, is clear on several key points.

At or about 05:10 Mr. Lewis attended at cell 11 when he first of all provided a blanket and then water. The visit is recorded by him on the ADM 51 (a) at 05:10 and this is supported by the CCTV footage and analysis.

The ADM 51 (a) shows a further entry at 06:01 “sitting up- is okay” entered by Mr. Lewis. This corresponds with the CCTV footage and analysis showing Mr. Lewis looking into cell 11 for a total of 17 seconds from 05:42.46 and then writing on the ADM 51 (a) form.

It is submitted that given the admissions made by Stewart Lewis in respect of non existent checks and false entries the 06:01 entry on the ADM 51 (a) might normally have been seriously suspect. However given that it is supported by CCTV it is submitted that in respect of this particular aspect there is in fact no serious cause to doubt the validity and accuracy of the 06:10 entry. It would be taking matters to the extreme to suggest that having looked into the cell for the length of period he did Mr. Lewis then wrote a completely fraudulent entry.

As discussed previously the 07:00 shift included Custody Care Assistant Alistair Smith. He gave evidence that he checked Mr. Batt in cell 11 and made an entry on the ADM 51 (a) at 07:06 “grunted”. He gave evidence that there was also a movement from Mr. Batt when he changed from lying on his back to lying on his right hand side **(11/05/09 ps 47 and 48)**.

His evidence of the visit itself, although obviously not the grunt or the movement, is supported by the CCTV showing a CCTV time of 06:47.26 **(CP 16)**.

Finally again as already mentioned Alistair Smith along with the other Custody Care Assistant David Massie attended at cell 11 at a CCTV time of 07:18.41 with an entry on the ADM 51 (a) at 07:36 “prisoner not responding. Custody sergeant informed.”

The red light outside cell 11 was not switched off at Mr. Lewis’ attendance at the cell at 06:01. It was ultimately switched off by Mr. Smith at his attendance at 07:06. It is submitted that there is no evidence to support a conclusion that the failure by Lewis to (a) switch off the cell 11 light at 06:01 and (b) to thereafter check cell 11 before going off shift contributed to Mr. Batt’s death.

On the basis of the evidence of Alistair Smith Mr. Batt was still alive at 07:06.

Professor Pounder in respect of his evidence and the post mortem report said that the cause of death was “adverse effects of heroin and Diazepam whilst in Police Custody”.

So far as the Diazepam was concerned he said in evidence that the “toxicology” indicates that Diazepam or Valium was recently used by the deceased, likely the evening or night before his detention. **(05/05/09 p 116).**

In respect of the use of heroin he gave some detailed evidence **(05/05/09 ps 117 to 129)** on the effect and result of taking heroin and morphine as derived from heroin. He pointed out that the interpretation of post mortem morphine levels was complicated by “the phenomenon of tolerance” **(05/05/09 p 118)**. In addition he indicated that any calculation was complicated by post mortem changes in the deceased which could alter the level of drug **(05/05/09 p 119)**.

He expressed the view that Mr. Batt was likely to have died “at least 20 minutes after taking heroin, and possibly more than an hour after” (05/05/09 p 120). He then went on to discuss the chemical basis for his view.

In response to a question from the Court he confirmed that Mr. Batt must have survived for at least 20 minutes but it was how much longer than 20 minutes that he couldn't really be certain about although he indicated Mr. Batt probably must have survived an hour (05/05/09 p 122).

It is therefore submitted that given the time scale from the taking of any heroin of 20 minutes up to one hour it is impossible to say that any check between 06:01 and 07:06 would have in any way prevented Mr. Batt's death.

The Red Warning Light System

The cells were/are fitted with a red warning light system. A prisoner can press a button in the cell which illuminates a red warning light in the corridor outside the cell door, a similar light in the main passageway at the end of the relevant cell corridor and illuminates board in the Custody Care Assistant's office.

The evidence and an inspection by the Court of the cell area demonstrated that the warning light/lights were not visible in the corridor which contained the fingerprint room and the kitchen. The light board in the CCA's office did not indicate the individual cell where the button had been pressed. Thus if one prisoner pressed his button to illuminate the light and

other prisoners then similarly illuminated their light anyone looking at the board would not be able to tell whether one cell light or say 5 cell lights were on.

So far as a time period for response to a red light was concerned the evidence showed that there was no specific time set down.

A distinction was drawn between the response time when a prisoner has been assessed as being of high vulnerability as opposed to low vulnerability.

It was generally agreed that if the cell light related to someone of high vulnerability then there should be if not an immediate response at least one as soon as was possible. In the case of a prisoner assessed as being of low vulnerability then a period of up to 10 minutes might be acceptable. One witness, Sergeant Gregor Stewart suggested that in certain circumstances up to 15 minutes might be acceptable. **(12/05/09 p 25)** No one suggested that anything beyond 15 minutes would be acceptable.

Cell Buzzers

The cells had a buzzer system which was linked to the red warning light. If a prisoner pressed the button inside his cell this should have had two effects (a) the red warning light would come on and (b) a buzzer would sound.

As a result of Mr. Batt's death Tayside Police Management became aware that the buzzer system had been switched off. A memo was issued by Inspector Gary Brown dated 19 December 2007 **(CP 76)**. This noted that the "cell prisoner calling system" had been found

to have been switched off. He advised that all cell buzzers had been reactivated and should not be deactivated unless there was a justifiable reason. As indicated in his memo and again seen on the inspection by the Court, each cell must have had its buzzer individually deactivated by moving the switch outside the cell door into the off position.

The evidence did not disclose for exactly how long the buzzers had been deactivated nor how this had come about whether by someone's specific instruction or otherwise. Some of the witnesses did not know there was such a system.

Clearly the buzzers should not have been switched off en masse, if that is what occurred. It was accepted that if an individual prisoner was misusing the cell button simply to annoy the staff then that would be a basis for switching the buzzer off provided the appropriate authority was obtained from the Custody Sergeant.

The CCTV System

The investigation by Fife Constabulary following Mr. Batt's death disclosed that the timing on the CCTV system was defective in that there was "slippage". One of the Custody Sergeants Allan Kidd had been unaware that there was such slippage **(07/05/09 p 170)**. Sergeant Gregor Stewart gave evidence that he was aware of the "slippage" and would on occasions go into the system and alter the system timing to the correct timing. **(12/05/09 p 128)**.

Within the evidence of Superintendent Hamish MacPherson there was considerable discussion of the technicalities of the CCTV timing **(04/06/09 p 76 to 84)** where he

confirmed that there was an arrangement in place at Perth to check CCTV timings. It was unclear whether the system being used in Dundee as at November 2007 was the same, technically, as the Perth system.

Integrity/UNIFI

The Integrity computer system now called UNIFI occupied a significant part of the evidence. At the end of the day the evidence would appear to result in the following points.

- a. Integrity started out with the inclusion of an intelligence function. This allowed the addition and retention of intelligence on individuals over and above convictions and outstanding charges or reports.
- b. The intelligence function was lost/discontinued when the Scottish Intelligence Database (SID) was brought in as a National System.
- c. It was technically possible for permanent warning markers to be put on the nominal (or first) page of an individual's entry on Integrity.
- d. The Custody Sergeant or other Custody Staff were not enabled (authorised) to make any alterations to the nominal page. This could only be done by staff with specific authority, apparently within the data input bureau.
- e. As a consequence the custody staff were unaware that it was possible to have information put on the nominal page by making a request to the data input bureau.

f. The overall result was that in order to see any markers Custody Staff would require to consult each of the individual custody records held on the Integrity System ie: if an individual had for example been in custody five times there would be five separate records.

g. When someone was taken into custody as at November 2007, checks were made by Custody Staff with the SCRO and PNC and any warning markers added to both the ADM 51 and ADM 19.

h. In the case of Mr. Batt staff had noted SCRO markers for “firearms, violent, mental, ailment”.

i. As the result of new software on the Integrity system now called UNIFI a change was being tested whereby a marker put on to an individual custody record automatically appears in the nominal (first) screen (12/05/09 p 167). This new software was demonstrated to the Court.

j. Appropriate training was being put in place for relevant users of the UNIFI system.

ADM 51, ADM 19 and the Assessment

It was the duty of the Custody Sergeant, Sergeant Allan Kidd to carry out an assessment of Mr. Batt.

As previously noted the relevant forms had been partially completed by PC Lindsay Dow and Gillian Kennedy. PC Dow brought Mr. Batt to the Charge Bar.

Sergeant Kidd then went in through the Charge Bar procedure which included the various questions on the ADM 51. He had available to him the written note of the markers from the SCRO search as well as PC Dow's comment that Mr. Batt "appears under influence of drink or drugs on arrest".

As can be seen from Sergeant Kidd's evidence and the CCTV footage, Mr. Batt is responsive, answers the various questions and appears able to probably converse with the Sergeant.

Sergeant Kidd's involvement in the procedure went further than normal. Because there was no male officer or member of staff present Sergeant Kidd himself searched Mr. Batt and then took him down and placed him in cell 11.

Sergeant Kidd had originally considered strip searching Mr. Batt. However, after questioning him, talking to him and searching him, Sergeant Kidd changed his mind. He was asked why he decided not to do a strip search and he explained the factors which caused him to change his mind and he explained the nature of a strip search **(07/05/09 p 64 to 68)**. Essentially he considered that taking everything into account such a search was not necessary. He stated that in reaching this view he had taken into account PC Dow's comment.

PC Dow herself confirmed that Sergeant Kidd was aware of her impression **(08/05/09 p 119)** but said that having been present at the Charge Bar during the assessment carried out by Sergeant Kidd she agreed with that assessment having spent more time with Mr. Batt **(08/05/09 p 127 and 128)**.

Of course Sergeant Kidd was unaware of Mr. Batt's previous drug history because he did not have access to previous AD 51 or ADM 19 forms in respect of Mr. Batt and there was no SCRO marker in respect of drugs, there not being drugs convictions or any outstanding charge or report in respect of a potential drugs offence.

Sergeant Kidd was asked if he had been aware of a history of drug use would that have altered his assessment. He responded that it would have on the basis that it was Tayside Police policy that anyone with a drug history, was known to use drugs or admitted at the Charge Bar that they took drugs, should then be stripped searched **(07/05/09 p 37)**.

The evidence generally was to the effect that a decision on whether or not to strip search someone involved a balancing of interests particularly given that the strip search was not a pleasant experience.

Sergeant Kidd gave a description of the strip search process **(07/05/09 p 67 to 68)**. The evidence confirmed that in a strip search those carrying out the search are not permitted to use a hands on approach. It is therefore perfectly possible for a prisoner to conceal an item including drugs internally despite a full and proper strip search. This was not uncommon.

It is submitted that on the information available to him, Sergeant Kidd properly assessed Mr. Batt and was entitled to reach the conclusions which he did in respect of vulnerability and no strip search.

There was considerable evidence and discussion over the retention in whatever form of the ADM 51 form and/or the ADM 19 Risk Form. At one time it appeared that the Custody Staff

in Dundee had kept up to 6 months worth of ADM 19 forms. This practice had been discontinued apparently because an instruction was received that to retain copy ADM 19 forms was contrary to Data Protection Law.

Evidence was heard from Chief Inspector Donald Thomson, a specialist in Data Protection, who advised that subject to certain safeguards and procedures it would not be a breach of Data Protection to retain copy ADM 19 forms. **(05/06/09 p 7 onwards)**

The technicalities of retaining either or both forms in some electronic format formed a subject of some of Superintendent MacPherson's evidence. He expressed the view that simply scanning these forms into a system was of little use. It would not be possible to search the forms.

It is submitted that if with the UNIFI update it is now possible to add markers of whatever description to the nominal page of a prisoner record, making available to Custody Staff previous ADM 51 and ADM 19 forms arguably becomes unnecessary. In addition if an individual is taken into custody at a station other than Dundee eg: in Perth the staff in Perth will have access to the UNIFI nominal page and therefore access to any markers thereon whereas they would not have access to the ADM 51 or ADM 19 forms from Dundee.

Custody Staff

All Custody Staff, both Police Officers and civilians were aware of and had access to the Tayside Police Prisoner Care Manual **(CP 15)**.

In the context of a consideration of the availability of staff Inspector Gary Brown said in respect of Custody Care Assistants “their principal role is care and welfare of prisoners”. **(03/06/09 p 213)**. He went on to say “Custody Care Assistants look after prisoners. That is their job.” **(03/06/09 p 214)**.

Against that background it was accepted that a Custody Sergeant would assess a prisoner as being high or low vulnerability and specify the nature of the checks to be carried out. Generally speaking prisoners assessed as low would require to be checked on an hourly basis and a verbal response was not required.

It was also accepted that all visits/checks to cells should be recorded on the cell sheet, the ADM 51 (a).

Against a background where the requirements of checking, recording and responding to red warning lights were well understood, it is difficult if not impossible to understand the approach of Stuart Lewis. Throughout his evidence he accepted that he had not carried out checks, had made false entries and had not responded properly to the red light system.

There was discussion during the evidence of Inspector Brown over whether or not another computer terminal was necessary in the Custody Care Assistant’s office, the current two being one being based in that office and one in the fingerprint room. **(03/06/09 p 210 to 212)**. The Inspector could see no real reason for another terminal. He did not consider that the amount of time that custody care assistants were required to spend on a computer necessitated another terminal.

There were clear operational guidelines on the use of computers to access the internet. Users required permission to obtain access to the internet but as explained in the evidence of David Flavell **(12/06/09 p 7 onwards)** there was a difficulty with the Bluecoat system which controlled usage. He explained that Bluecoat should have shut down a second proxy server through which some of the Tayside Police users were obtaining access to the internet. He explained that the computers of some users were not being directed to the Bluecoat server but to the second proxy server. Mr. Flavell advised that this meant that some users were effectively gaining unauthorised access and this didn't come to light until February 2008 **(12/06/09 p 15)**.

In the course of the evidence he gave on 29 June 2009 **(p 3 onwards)** Mr. Lewis accepted that he had been using the internet during his shift of 27/28 November 2007. He accepted that a very large number of the sites he had been on had clearly nothing whatsoever to do with his work as a Custody Care Assistant. There was clearly no way he should have been using the internet in the fingerprint office in a position where he could not see the red light system and against the background where his function was prisoner care. He denied knowing about the Information Security Policy **(p 11)** but accepted that he had signed the relevant form. **(p 14)**

Mr. Lewis was on duty with Custody Care Assistant Linda Peddie. He did not appear to consider it necessary to advise Linda Peddie or indeed any colleagues when he was leaving the cell area. On the other hand Linda Peddie considered that it was necessary to advise her colleagues when she left the cell area.

The question of the relationship between the duties of a male and female Custody Care Assistant was considered with Inspector Brown. He expressed a view that it was the duty of both to look after both male and female prisoners, subject to obvious restrictions such as not expecting a female member of staff to go into a male cell or vice versa **(03/06/09 p 116 to 119)**. Inspector Brown said at **p 119** “yes, they work as a team. I know they do.” On that basis there was nothing untoward or any compromise on prisoner care to have one male and one female Custody Care Assistant on a shift. This view was supported by Superintendent Ross **(29/06/09 p105 to 107)**

Custody Changes and Developments

Various witnesses including Superintendent Hamish McPherson and Inspector Gary Brown spoke to the operation of a Custody User Group. As at November 2007 the Group was chaired on a rotational basis by a Chief Inspector from one of the Divisions.

From April 2008 various changes came into effect including the chairing of the Group by a Detective Superintendent. The role was taken by Superintendent Roddy Ross **(29/06/09 p 62)**.

Superintendent Ross explained that Tayside Police considered it was necessary and that rather than matters being dealt with at each Divisional Chief Inspector level, responsibility for custody and all criminal justice policy would be brought into a central role **(p 63)**. The Superintendent went on to explain the make up of the group **(p 64 onwards)** and confirmed that it was responsible for guidance on policy, IT provision and training. He said “that

generally covers the whole breath of policy issues and of course the significant policy area is medical care, hence the representation from our supplier” **(p 65)**.

He outlined how the group operated in terms of regular meetings, discussions, reviews and recommendations.

As at November 2007 Tayside Police operated with their own Prisoner Care Manual. However development work had taken place on a National Custody Manual for use by all of the Scottish Police forces. He advised that manual had been adopted for use in Tayside from 1 May 2009. **(p 68 and 69)**. This manual replaced the Tayside manual. The purpose was to “try and establish a new National approach” **(p 70)** and there had been various reviews to compare the Tayside manual against the new National one. There was provision for local conditions **(ps 70 and 71)**.

He went on to explain how the manual dealt with risk assessment with information being a key element in managing risk.

He referred to the installation of the new Charge Bar facilities in Dundee. **(p 72)**

In respect of available information he spoke to the amendment to the UNIFY system where it ought now to be possible to add a warning to the nominal page **(ps 81 and 82)**.

In discussion with the Court **(ps 84 to 86)** Superintendent Ross accepted that certain types of information would appear only in the ADM 51 form and no where else. At page 56 he says “yes and that’s clearly a gap which”. A section of tape is then missing or defective but it is

understood that Superintendent Ross advised that the Custody Users Group could consider how best to deal with this “gap”.

One major change since November 2007 relates to the provision of medical care in custody. Superintendent Ross spoke to the implementation of a contract with NHS Tayside **(p 92 onwards)**. Under the “old” system if custody staff considered that medical attention was required for a prisoner they either had to call the Police doctor or take the prisoner to hospital. While Custody Staff had First Aid and related training, they had no medical training as such or medical qualifications.

A full description of the new procedure for medical care can be found in the evidence of Dr. Magdalayna Turowska **(02/06/09 p 49 onwards)**. Dr. Turowska confirmed that the new system involved two nurses permanently on shift, one present at Dundee and the other travelling as necessary to Perth and Arbroath **(p 52)**. Occasionally there could be an additional third nurse **(p 53)**.

Dr. Turowska made it clear that while a nurse would assess a patient and his/her symptoms the assessment was a medical one only **(ps 55 and 56)**.

Under the new system the nurses and doctor had a database available to them which they themselves operated, separate from any Tayside Police database. Because the contract was with NHS Tayside there were links to an individual’s own NHS medical records which clearly gave or potentially gave a much clearer picture of that individual’s medical background. The doctor did however make it clear that although the nurses and doctors

referred to their own database as “the Police database” the Police themselves did not have access to it.

Nevertheless the introduction of the contract with NHS Tayside is it is submitted a major step forward in prisoner care both in terms of increasing the quality of care available to the prisoners and giving Custody Staff immediate access to a medically qualified person ie: a nurse.

Superintendent Ross spoke to improvements in training for Custody Staff and outlined the new training program and it’s modules. **(29/06/09 ps 108 to 111)** He said that “part of the remit was to try and focus training very much on what people needed to know” **(p 110)**.

Superintendent Ross’ evidence also considered the changes set out in the National Custody Manual on “monitoring and observations” **(ps 111 to 117)**. In particular he spoke to category of intermittent observation as appropriate for those being suspected of being intoxicated through drink or drugs. The Manual provided that the custody should be visited and roused at least every 30 minutes and positively engaged at frequent and irregular intervals **(ps 114 and 115)**. He confirmed that this was to avoid any danger of a prisoner recognising a pattern of visits. If they knew there was going to be a visit every 30 minutes then they could use this to reduce the chances of being caught taking concealed drugs **(ps 115 and 116)**.

The Superintendent confirmed that to implement the provisions of the Manual dealing with or an inspection Tayside Police had put in place an audit and inspection regime. This covered both paperwork and cells and equipment **(ps 120 to 123)**.

Kristoffer Batt

The late Mr. Batt was a drug abuser. He consumed the drugs responsible for his death. His decision to abuse his body through taking such substances effectively resulted in him killing himself. He decided to take drugs in advance of being taken into custody and deliberately concealed drugs on his person when taken into custody