SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2025] FAI 34

GLW-B366-23

DETERMINATION

BY

SHERIFF MICHAEL HANLON

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

into the death of

DECLAN GALLACHER

and

DAVID BERRY

GLASGOW, 31 July 2025

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

Death of Declan Gallacher

(1) in terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"), that Declan Gallacher, born on 13 December 1994, died on 23 December 2018 between 0240 hours and 0422 hours, the exact time being unknown, at Clydebank Police Office;

(2) in terms of section 26(2)(b) of the Act, that no finding is made as the death was not the result of an accident;

(3) in terms of section 26(2)(c) of the Act, that the cause of death was alcohol, benzodiazepine and pregabalin intoxication;

(4) in terms of section 26(2)(d) of the Act, no finding is made as the death was not the result of an accident;

(5) in terms of section 26(2)(e) of the Act, no finding is made that there was any precaution which (i) could reasonably have been taken; and (ii) had it been taken, might realistically have resulted in the death, being avoided;

(6) in terms of section 26(2)(f) of the Act, no finding is made that there was any defect in a system of working which contributed to the death;

(7) in terms of section 26(2)(g) of the Act, that there were a number of facts relevant to the circumstances of the death which are discussed further below, namely:

(i) The procedures followed in the strip search of Mr Gallacher;

(ii) The procedure followed when processing Mr Gallacher following his arrest;

(iii) The procedure followed in the cell visits by custody staff to Mr Gallacher;

(iv) The conduct of constant observations of Mr Gallacher by custody staff via CCTV; and

(v) The procedure followed when considering whether to refer Mr Gallacher to a Health Care Professional.

Death of David Berry

(1) in terms of section 26(2)(a) of the Act, that David Berry, born on 25 December 1969, died on 11 July 2020 between 1126 hours and 1218 hours, the exact time being unknown, at Govan Police Office;

(2) in terms of section 26(2)(b) of the Act, no finding is made as the death was not the result of an accident;

(3) in terms of section 26(2)(c) of the Act, that the cause of death was seizure related to epilepsy, and cardiac enlargement with myocardial fibrosis; and chronic alcohol abuse;

(4) in terms of section 26(2)(d) of the Act, no finding is made as the death was not the result of an accident;

(5) in terms of section 26(2)(e) of the Act, no finding is made that there was any precaution which (i) could reasonably have been taken; and (ii) had it been taken, might realistically have resulted in the death, being avoided.

(6) in terms of section 26(2)(f) of the Act, no finding is made that there was any defect in a system of working contributed to the death;

(7) in terms of section 26(2)(g) of the Act, that there were a number of facts relevant to the circumstances of the death which are discussed further below, namely:

    (i) The procedure followed when processing Mr Berry following his arrest, with particular regard to prescriptions in his possession;

    (ii) The procedure followed in the cell visits by custody staff to Mr Berry;

(iii) The conduct of constant observations of Mr Berry by custody staff via CCTV;

(iv) The procedure followed when considering whether to refer Mr Berry to a Health Care Professional.

RECOMMENDATIONS

The Sheriff, having considered the information presented at the Inquiry in respect of both deaths, makes the following recommendations in terms of 26(1)(b) of the Act:

1. That Police Scotland update the National Custody System to include a separate mandatory field confirming whether a strip search of a prisoner is to take place, as well as recording that the decision has been communicated to the prisoner and the officer to conduct the search.
2. That Police Scotland update the National Custody System to introduce a mandatory field in the processing of prisoners, confirming that system checks of all relevant databases has been completed in relation to each prisoner.
3. That Police Scotland update the National Custody System to ensure that, whatever level of constant observation is decided upon for a prisoner, the system allows custody officers to separately choose the appropriate regime for prisoner visits without having to first change the level of constant observation to a lower level.

4. That Police Scotland give urgent consideration to introducing formal written guidance to officers as regards the maximum ratio of observing officers to prisoners for constant observations.

5. That Police Scotland give urgent consideration to introducing a formal policy, set out in its Standard Operating Procedures, as regards the period following which a break should be provided for officers conducting constant observations, and to introducing a system whereby such breaks are the subject of a system of recording.

6. That Police Scotland introduce a module of training on constant observations, formally outlining what the duty entails, the risks involved, what signs to look for and what action to take in potential scenarios, and that an accessible record be kept to ensure that those placed on constant observation duties have completed the appropriate training.

7. That Police Scotland, in collaboration with the NHS healthcare hub staff, review the guidance to police officers as set out in the Standard Operating Procedures in relation to when a referral of a prisoner to a Health Care Professional should be made, that it sets out with greater clarity the criteria used in deciding whether a referral should be made, and addresses the issue of whether or not there exists any minimum wait time for a Health Care Professional to attend.

NOTE

Representation

Procurator Fiscal: Carey, Procurator Fiscal Depute

Declan Gallacher's family: Sweeney, solicitor

David Berry's family: Clarke, lay representative

Police Sergeants Alan McKenzie and Andrew McGhee: Vaughan, solicitor advocate

Police Constables Whyte and Johnstone: Watson, solicitor advocate

Police Custody and Security Officers Boyd, Marrone and MacIness: Rodgers, solicitor

Police Custody and Security Officer Gildea: Kavanagh, solicitor

Chief Constable for Police Service of Scotland: Railton, solicitor

Greater Glasgow Health Board: Paton, solicitor

Introduction

[1] This was an Inquiry held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 into the deaths of Declan Gallacher and David Berry. A notice of Inquiry was given by the Procurator Fiscal under section 15(1) of the Act on 13 March 2023 in respect of both deaths. As Mr Gallacher and Mr Berry were each in legal custody at the time of their respective deaths this was a mandatory Inquiry in terms of section 2(4)(a) of the 2016 Act. The Procurator Fiscal asked that the inquiries in relation to each death be conjoined as the deaths of both deceased occurred while they were in police custody at a police station under constant observations by the police.

[2] A first preliminary hearing took place on 12 May 2023. There followed a number of preliminary hearings during which time evidence was secured and disclosed. A number of parties intimated a notice of intention to participate. In addition, during this time, parties undertook to consider and agree a significant amount of the large number of productions and statements lodged. Ultimately, parties entered into five separate joint minutes of agreement, dealing in detail and comprehensively with much of the evidence and many of the issues raised by the deaths of Mr Gallacher and Mr Berry. I am very grateful to parties for the care taken in preparing these and for their ongoing assistance. Evidence was heard over 12 days from 5 August 2024 to 22 January 2025. Thereafter, detailed submissions were prepared by all parties, for which I am again grateful. A hearing on submissions took place on 15 April 2025, when the court made avizandum.

[3] Parties agreed that statements or affidavits from the following witnesses should be accepted as their evidence to the Inquiry: (i) Gillian McLeod, Police Custody Security Officer Team Leader; (ii) Ross Clark, Police Inspector; (iii) Sharon Campbell. Police Custody Healthcare Interim Senior Charge Nurse for Greater Glasgow and Clyde Health Board; (iv) Lorna Shaw, Paramedic; (v) Doctor Richard Stevenson, MBChB, BMSc (Hons), DMedTox, MFFLM, RCEM; (vi) Anthony Fitzpatrick, Police Inspector; (vii) Doctor Gemma Kemp, MBBS, FRCPath; and (viii) Doctor Julia Bell, FRCPath, DipFMS, DMJ(Path). In addition reports from (i) Doctor Kieren Allinson, BSc (Hons), MBChB, FRCPath(Neuro); and (ii) Doctor Rudy Crawford MBE, BSc (Hons), MBChB, FRCS, FRCEM were lodged as productions.

[4] The Inquiry heard parole evidence from the following witnesses:

(i) Nathan Donnelly, Police Constable; (ii) Daryl Johnstone, Police Constable; (iii) Kenneth McCann, former Police Custody Security Officer; (iv) Robert Campbell, former Police Custody Security Officer; (v) Duncan Whyte, Police Constable; (vi) Donald MacInnes, Police Custody Security Officer; (vii) Gary McKenzie, Police Inspector; (viii) Andrew Gunn, Police Inspector; (ix) John Boyd, Police Custody Security Officer; (x) Julie Marrone, Police Custody Security Officer; (xi) Garth Gildea, Police Custody Security Officer; (xii) Andrew McGhee, Police Sergeant; and (xiii) Margaret Nicolson, former Police Inspector.

[5] Police Inspector Gunn and former Police Inspector Nicolson each gave opinion evidence as skilled witnesses based on their operational, senior managerial and review experience with Police Scotland in relation to custody suites in Scotland. A number of witnesses have changed status since the deaths of Mr Gallacher and Mr Berry, whether through promotion or having left the employment of Police Scotland. For ease of reference, their rank or status is given as at the time of the respective deaths unless otherwise stated.

The legal framework

[6] The Inquiry was held under section 1 of the Act. In terms of section 1(3) of the Act, the purpose of the Inquiry was to establish the circumstances of the deaths and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. In terms of section 1(4) of the Act the purpose of an Inquiry is not to

establish civil or criminal liability. The procurator fiscal depute represents the public interest. An Inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination in an Inquiry must be based on the evidence presented at that Inquiry.

[7] In terms of section 26 of the Act, the sheriff must make a determination setting findings in relation to the following circumstances:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided;

(f) any defect in any system of working which contributed to the death or to the accident; and

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

[8] Also in terms of section 26 of the Act, the determination made by the sheriff may set out such recommendations in relation to the following matters which might realistically prevent other deaths in similar circumstances as the sheriff considers appropriate:

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) the taking of any other steps.

Analysis of evidence

[9] There is little in dispute concerning the background and circumstances of the respective deaths of Mr Gallacher and Mr Berry. In particular, the timing, location and cause of each respective death were not in dispute. The evidence as regards these matters was set out in a joint minute of agreement by parties. The evidence agreed in that joint minute forms the basis of the findings set out above in relation to section 26(a) to (d) of the Act. There follows a general summary of those matters. Thereafter, I set out particular issues which arose in relation to the deaths which were the subject of more detailed evidence and submissions, and which raise issues that merit more detailed consideration. These issues include a consideration of precautions which might have been taken in respect of each death, and of potential defects in the system of working in terms of section 26(e) and (f) of the Act. For the reasons set out when considering these issues, I conclude that there is no evidence that any precaution which could have been taken might realistically have resulted in either death being avoided or that any defect in any system of working contributed to either death. The issues considered do however concern facts which are relevant to both deaths in terms of section 26(g) of the Act.

Background and circumstances of deaths

Declan Gallacher

[10] Declan Gallacher was born on 13 December 1994. He resided between his uncle's address in Paisley and his partner's address in Lancaster. He had one child. Mr Gallacher had a number of previous convictions and had been sentenced to imprisonment on a number of previous occasions. He was released from prison on licence on 22 May 2018, with his period of licence due to expire on 8 January 2019.

[11] Mr Gallacher reported heavy benzodiazepine use. He was known to take diazepam, cocaine, ecstasy and cannabis and to abuse alcohol. His medical notes also provided evidence of his drug use, as well as his struggles with low mood, anxiety, self-harm, and suicidal thoughts, including thoughts of jumping from the Erskine Bridge, during a period of family bereavements. On 3 November 2018 he was admitted to the Royal Lancaster Infirmary, having suffered a seizure, with a left-sided head injury and small fracture of the medial orbital wall. On several occasions, whilst in prison, he was prescribed diazepam for detoxification purposes. He was not prescribed any medication at the time of his death.

[12] At 0059 hours on 23 December 2018, Mr Gallacher was walking on the slip road which leads off the northbound carriageway of the Erskine Bridge, leading on to the A82 road. He was walking towards oncoming traffic and a taxi driver had to swerve to avoid him. An off-duty police officer in the taxi telephoned 101 and reported this, stating that Mr Gallacher ultimately might be located in the middle of the bridge. At 0101 hours on 23 December 2018, Police Constables Martin Blue and

Christopher McCrate attended the Erskine bridge. They arrived in a marked police vehicle at around 0115 hours and were joined by other officers shortly thereafter. Mr Gallacher was walking on the pedestrian footpath. Both officers approached Mr Gallacher and explained they had received a call about him. Mr Gallacher began shouting and swearing at them. He was warned regarding his behaviour, but continued to shout and swear at the officers. He was arrested for a contravention of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010 and placed in handcuffs.

[13] Police Constables Blue and McCrate walked Mr Gallacher to a waiting police vehicle. Mr Gallacher was searched and was found to be in possession of a mobile phone and wallet. He then entered the cell area of the police vehicle and sat down on the bench within. He appeared under the influence of a substance and his speech was slurred, but was otherwise lucid and appeared alert. He was transported to Clydebank Police Office. Police Constable McCrate sat in the rear of the vehicle where he could observe Mr Gallacher. Mr Gallacher vomited in the cell van en route to Clydebank Police Office. Police Constable McCrate asked Mr Gallacher if he was ok and he replied "Aye, I just whiteyed a wee bit." Mr Gallacher arrived at Clydebank Police Office at approximately 0130 hours on 23 December 2018 and entered it at around 0139 hours. He was initially taken to the holding cell within the police office for just a few minutes before being escorted to the charge bar area.

[14] The custody suite at Clydebank Police Office contains 29 cells located on the ground floor. CCTV covers several areas within the police office, including the

holding/reception area and the cell corridor on the ground floor. In addition, there are CCTV cameras in cells 1 to 4 with a remote observation facility from a CCTV monitoring room adjacent to the custody suite. Cell 3, where Mr Gallacher was ultimately placed, was used as an observation cell. It has a toilet fitted on the wall to the right at the entrance of the cell. Directly opposite the cell door there is a raised area with a mattress and pillow. Cell 3 is equipped with a CCTV camera. The CCTV camera in Cell 3 is in the corner of the ceiling above the mattress within the cell.

[15] At around 0146 hours Mr Gallacher was processed on the Police National Custody System (NCS) by Police Custody and Security Officer (PCSO) Robert Campbell and his arrest was thereafter authorised by Police Sergeant Gary McKenzie. The NCS is a computer-based system on which a full record is kept of a prisoner's time in custody. Mr Gallacher was asked several questions in relation to his wellbeing. He stated that he had no injuries, was not dependent on alcohol, had never attempted self-harm or suicide, had no current thoughts of self-harm or suicide, was not suffering from any ongoing medical conditions, and was not taking any prescribed medication. He confirmed that he had consumed alcohol in the preceding 24 hours. He initially stated that he had not consumed drugs in the preceding 24 hours and was not dependent on drugs, but subsequently disclosed that he had taken Xanax that day and that he would usually consume fifteen to twenty Xanax each day. He confirmed that he suffered from symptoms of Valium withdrawal and recently had a seizure. Following checks on the Police National Computer and Criminal History Databases, Police Sergeant McKenzie

was informed that Mr Gallacher had 14 previous convictions and was on licence, but was not on bail, had no pending criminal matters, and no outstanding warrants.

[16] Police Sergeant McKenzie decided that Mr Gallacher required a "high" level of supervision whilst in police custody and should be placed under "constant observations," also known as Level 3 observations. Level 3 constant observations required officers or members of staff to constantly monitor a prisoner via a CCTV facility and to physically check on the prisoner at least once every 60 minutes. At around 0154 hours, Mr Gallacher was subject to a "standard search", carried out at the charge bar by PCSO Donald MacInnes in the presence of Constables Blue and McCrate and PCSO Campbell. Headphones, a mobile phone, a wallet, gloves, a jacket, and trainers were recovered and retained. Police Sergeant McKenzie noted in the NCS that he had authorised a strip search of Mr Gallacher due to his drug use. However, a strip search was not carried out.

[17] At around 0158 hours, Mr Gallacher was escorted to Cell 3 by Constables Blue and McCrate and PCSO MacInnes. PCSO MacInnes provided him with a blanket and asked him if he wanted a glass of water, and he was then left alone in the cell. At around 0200 hours, PCSO Donald MacInnes returned to Cell 3 and gave Mr Gallacher a cup of water and a cereal bar through the cell door hatch. This was documented on the Prisoner Contact Record (PCR). It was not recorded on the NCS. The PCR was a handwritten record located outside the cell on the wall next to the cell door, used to record any visits or movements by the prisoner. The record is created at the time of booking a prisoner into custody. At 0202 hours, PCSO MacInnes returned to Cell 3 and

spoke to Mr Gallacher through the cell door hatch for approximately 1 minute before closing the hatch and leaving Mr Gallacher alone in the cell. It was the intention of the police to release Mr Gallacher from custody once no longer intoxicated and to report him to the Procurator Fiscal for the alleged section 38 offence. Police Sergeant McKenzie documented this decision on Mr Gallacher's custody record at 0158 hours and at 0204 hours. The NCS records that welfare checks were carried out on Mr Gallacher at 0230 hours and 0330 hours, and that a verbal response was obtained from him on each occasion. In fact no verbal response was obtained at 0230 and no check took place at 0330.

[18] At 2330 hours on 22 December 2018 Police Constable Duncan Whyte commenced observation duties on four prisoners on one monitor via the CCTV facility at Clydebank Police Office. At 0154 hours on 23 December Police Sergeant Gary McKenzie informed PC Whyte that he would be responsible for a further prisoner, Mr Gallacher, on a second monitor. Sergeant McKenzie informed Constable Whyte that assistance in conducting observations had been requested from another police officer from Helensburgh Police Office. CCTV footage from Cell 3 shows Mr Gallacher putting his hand towards his waistband and then briefly towards his mouth at 0206 hours. On the footage, between 0240 and 0243 hours Mr Gallacher appears to suffer a seizure, with his chest rising and falling and his limbs shaking. He vomits, lies back down and thereafter remains motionless. This was not noticed by PC Whyte. Police Constable David Quigley took over CCTV observations at 0250 hours on 23 December. He did not

identify the vomit on Mr Gallacher's face or on the cell floor, nor notice anything which caused him concern.

[19] At 0348 hours on 23 December 2018 PCSO MacInnes was conducting prisoner welfare checks. On attending Cell 3, he lifted the hatch in the door in order to speak to Mr Gallacher. He observed Mr Gallacher lying on his back on the mattress within the cell with his eyes open looking up towards the ceiling. Mr Gallacher had vomit on his mouth and on the chest of his shirt. PCSO MacInnes opened the cell door and shouted for help. He entered the cell, slapped Mr Gallacher on the face, before pulling his left arm, rolling him onto his front, slapping him on the back and shaking him. He received no response. PCSO Campbell then arrived at Cell 3 and activated the panic alarm situated outside the cell on the cell corridor wall. Sergeant McKenzie along with Police Constables Liam Monaghan and Daniel Bryant, and PCSO McKenzie then rushed towards the cells from the charge bar area.

[20] Sergeant McKenzie and PCSO Campbell entered Cell 3. PCSOs Campbell and MacInnes moved Mr Gallacher onto his back and commenced cardiopulmonary resuscitation (CPR), whilst Constable Monaghan returned to the charge bar area and telephoned for an ambulance. Sergeant McKenzie left Cell 3 at 0349 hours to look for a defibrillator, retrieved a red emergency response bag from the nurse's room and quickly made his way back to the cell. At 0350 hours Sergeant McKenzie began searching the bag for a defibrillator but did not find one within. He provided PCSOs Campbell and MacInnes with a CPR mask from the bag and they continued CPR on Mr Gallacher. Sergeant McKenzie continued to look in the bag for a defibrillator before returning to

the charge bar area. Police Constable Alan King found the defibrillator within a different red bag in the medical room. He gave this to Sergeant McKenzie, who made his way back to Cell 3. At 0352 hours Sergeant McKenzie, and PCSOs Campbell and MacInnes attempted to use the defibrillator on Mr Gallacher, however the device indicated that his heart rhythm was asystole (no electrical activity), which meant that the defibrillator could not be used to shock the heart. CPR continued until the arrival of paramedics.

[21] At Around 0400 hours, Diane Smith, Ambulance Technician, and Jared Paul Smith, Paramedic, both from the Scottish Ambulance Service, arrived and entered Cell 3. Diane Smith took over chest compressions on Mr Gallacher. Jared Smith prepared the defibrillator, placed new defibrillator pads on Mr Gallacher and removed the pads applied by PCSOs Campbell and MacInnes. Again, the machine indicated an asystolic rhythm. At around 0402 hours, John Beavis, Ambulance Technician, and Craig Dunn, Paramedic, both from the Scottish Ambulance Service, entered Cell 3. Craig Dunn cannulated Mr Gallacher and administered adrenaline. Jared Smith noted that Mr Gallacher's mouth was full of vomit and used a suction device in an attempt to clear his airway. Jared Smith also gave Mr Gallacher fluid through his humerus. Meanwhile, Diane Smith and John Beavis continued to assist by performing CPR and maintaining Mr Gallacher's airway. The crew performed advanced life support for approximately 20 minutes. Mr Gallacher failed to respond to the treatment and his heart rate remained asystolic. At 0422 hours active treatment and CPR ceased. There was a group decision to pronounce Mr Gallacher's life extinct at 0422.

[22] Mr Gallacher was left within Cell 3, which was secured pending scene examination protocols being instigated. A Crime Scene Manager and Police Investigation and Review Commissioner (PIRC) investigators attended. Photographs were taken of Cell 3, with Mr Gallacher still *in situ*, and of other areas where Mr Gallacher had been, including the cell corridor on the ground floor, the interior and exterior of the van which had been used to transport him to Clydebank Police Office, and the charge bar area. Photographs were also taken of the observation room and the CCTV monitor within the observation room. Mr Gallacher was visually examined. He had no obvious fresh injuries or marks. His body was thereafter removed to the mortuary at the Queen Elizabeth University Hospital for post-mortem examination.

[23] On 31 December 2018, a post-mortem examination was carried out on Mr Gallacher's body at the Queen Elizabeth University Hospital, Glasgow by Doctor Gemma Kemp, Forensic Pathologist, and Doctor Sharon Melmore, Forensic Pathologist, who prepared a post-mortem report, which gave the cause of Declan Gallacher's as "1a. Alcohol, benzodiazepine and pregabalin intoxication." The conclusions section of the post-mortem report stated:

> "Post mortem findings indicate that Declan Gallacher died as the result of alcohol,benzodiazepine and pregabalin intoxication.
> …
> Toxicological analyses of the blood and urine found high levels of alcohol. There was a low level of the cocaine metabolite benzoylecgonine in the blood, but as no active cocaine was identified this is not considered to be significant. Alprazolam and etizolam, substituted benzodiazepine drugs which are not licensed for medicinal use in the United Kingdom, were found in the blood. Pregabalin, an anticonvulsant/analgesic drug which was not prescribed to Mr Gallacher was found in the blood at a level within the therapeutic range, but Mr Gallacher may have been a naive user of this drug. Alcohol,

> benzodiazepines and pregabalin are all sedative drugs which when taken in combination and/or in excess can cause respiratory depression, coma and death. This mode of death correlates with the background circumstances..."

David Berry

[24] David Berry was born on 25 December 1969. He was not married and had no children. He had 58 previous convictions dating from 1986. He was recalled to prison from 4 March 2020 in terms of section 16 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 and imprisoned for 60 days. On 11 May 2020 he appeared at Falkirk Sheriff Court in relation to a contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010 and was sentenced to 4 months' imprisonment. He was released from HMP Low Moss on 10 July 2020 between 0830 hours and 0930 hours. He was issued with his property, a quantity of money, a travel warrant and two NHS prescriptions dated 25 June 2020: one for lamotrigine, a medication which can be used to treat seizures; and another for ibuprofen and co-codamol.

[25] Mr Berry had a history of alcohol abuse and intravenous drug use, with related seizures and chronic back pain. He was admitted to different hospitals in Scotland on a number of occasions between 2008 and 2019. In the period prior to his death, he had suffered a number of seizures resulting in medical interventions:

a. On 8 January 2019 he had a seizure in the waiting area at a Prison Health Centre. He had previously been prescribed anti-convulsant medication and a discussion was had for the medication to be recommenced.

b. On 14 January 2019, he was found unresponsive in his prison cell having had a seizure. He was sent for an MRI scan in the days that followed.

c. Between 15 and 17 February 2019, he suffered seven seizures in HMP Glenochil. On 19 February 2019, he was admitted to Forth Valley Royal Hospital. He was prescribed an anti-epileptic medication Levetiracetam.

d. On 29 July 2019 at HMP Glenochil he reported he was suffering from chronic back pain and had previously had seizures.

e. On 8 and 9 August 2019, he had two seizures. He had not been taking his anti-convulsant medication after being liberated from HMP Glenochil. He had been consuming alcohol and heroin. He was prescribed lamotrigine.

f. On 11 September 2019 at HMP Glenochil he was abusing alcohol and suffering from drug withdrawal. He had epileptic seizures and lower back pain. He was prescribed lamotrigine and co-codamol.

g. From 8 December 2019 he suffered uncontrolled fits and was admitted to Forth Valley Hospital on 11 December 2019. He received diazepam whilst an inpatient but otherwise no changes were made to his usual anticonvulsants. He was seizure-free for 12 hours before being discharged.

h. On 15 December 2019 he was admitted to Forth Valley Hospital, after displaying erratic behaviour and was suspected to be intoxicated.

i. On 3 February 2020 while within HMP Glenochil he was referred to addiction services to discuss pre-release harm reduction surrounding drug and alcohol misuse. He was transferred to HMP Perth and referred to the

health centre there, due to seizures and recommendations regarding his dosage of the anticonvulsant lamotrigine.

j. On 27 February 2020, he suffered a seizure which lasted approximately 7 minutes in HMP Perth. He was admitted to the prison healthcare centre and observed overnight. The seizure was caused by the Mr Berry's failure to take his prescribed dose of lamotrigine.

k. On 23 March 2020, Mr Berry had two seizures. He was reviewed by the GP at HMP Perth and was observed for a period.

l. On 11 May 2020, at HMP Low Moss, it was noted that he required medical attention as he had a "trapped nerve in back, crushed vertebrae, takes fits seizures".

m. His last prescriptions for lamotrigine and for ibuprofen and co-codamol were issued at HMP Low Moss on 25 June 2020. He had these prescriptions in his possession when he was released from prison.

[26] At 1830 hours on 10 July 2020, Mr Berry was sitting on a bench outside a supermarket at 1 Port Dundas Place, Glasgow. He was drinking from a bottle of whisky, singing, and talking to passers-by. A security officer from the store saw him lying back on the bench in an obscure position, with his head tilted backwards. He appeared to be unconscious so the security officer approached him and placed him in the recovery position and an ambulance was arranged. About 1900 hours, Police Constables Ben Moore and Stephen Thomson attended. They confirmed that Mr Berry

was conscious, breathing, and able to engage while they awaited the arrival of the ambulance.

[27] About 1910 hours on 10 July 2020 Constables Moore and Thomson updated Ambulance Technician Lorna Shaw who had arrived at the scene. Mr Berry was at that time categorised as being a low, immediate, clinical risk. Police officers found paperwork on Mr Berry, including the prescription for lamotrigine. Mr Berry's speech was slurred and he was noted as being intoxicated. Lorna Shaw transported him by ambulance to the Accident and Emergency Department of Glasgow Royal Infirmary as a precautionary measure. They arrived at approximately 1931 hours. Constable Moore informed the police control room of what had happened, that the police officers were standing down, and that Mr Berry was to be taken to hospital by the ambulance crew. The full details were recorded in a STORM (System for Tasking and Operational Resource Management) Incident Report, a method by which events are recorded by those employed by Police Scotland. There is no reference in said STORM Report to the prescriptions found on Mr Berry.

[28] At Glasgow Royal Infirmary, Mr Berry was triaged and assessed by Nurse Geraldine Sparkes. He was intoxicated, but had no obvious injuries. At 2020 hours he was examined by Dr Richard Stevenson, an Accident and Emergency Consultant, who found him to be intoxicated with alcohol and verbally abusive. Dr Stevenson had sight of Mr Berry's NHS prescriptions. He considered Mr Berry fit for discharge. However, Mr Berry refused to leave, and was aggressive and verbally abusive. Assistance was sought from hospital security to escort him from the premises. The police were

contacted and Constables Nathan Donnelly, Thomas Ross, Rob Cunninghame and Alison McGuire attended. They approached Mr Berry, who shouted and swore at them. At 2105 hours he was arrested outside the A&E Department by Constables Donnelly and McGuire for a contravention of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010. Constable Donnelly spoke with Dr Stevenson. Mr Berry was initially conveyed to Stewart Street Police Station, Glasgow. During this time he continually shouted and swore at Police Constables and made sectarian remarks. He was then conveyed to Govan Police Office, Glasgow by Police Constables Bilal Rana and Daryl Johnston.

[29] All areas of the custody suite in Govan Police Officer are covered by CCTV. There are a number of observation cells, which are fitted with CCTV cameras that can be monitored remotely from either of two observation rooms within the custody suite. Cell 16, where Mr Berry was ultimately placed, has a toilet fitted on the wall on the left-hand side of the room, a CCTV camera is mounted in the corner of the ceiling to the right of the doorway as you enter the cell. There is a raised area directly opposite the cell door where a mattress was placed at the time. In July 2020 the observation room had three monitors. Each monitor could display up to four prisoner cells at the same time.

[30] Mr Berry arrived at Govan Police Office on 10 July 2020 at 2235 hours; he was handcuffed to the rear and supported by Constables Rana and Johnston as he was walked from the police cell van to the custody suite. He was stooped forward and staggering. He was taken to the holding area and then to the charge bar, again

supported by Constables Rana and Johnston. At 2307 hours he was accepted into custody by Police Sergeant Andrew McGhee, after Constable Johnston explained the circumstances that had led to his arrest and that Mr Berry had been deemed fit to be detained by Dr Stevenson at Glasgow Royal Infirmary. This information was provided to Constable Johnston by the arresting officer, Constable Donnelly. Sergeant McGhee authorised Mr Berry's arrest and instructed PCSOs Julie Marrone and Garth Gildea to process him on NCS. It is incumbent upon custody staff to carry out the following systems checks before a prisoner is presented at the charge bar:

a. Police National Computer (PNC)

b. Criminal History Service (CHS)

c. Scottish Intelligence Database (SiD)

d. Vulnerable Persons Database (iVPD)

e. Adverse Custody Records

f. National Custody System (NCS)

Checks were carried out in relation to Mr Berry on the Police National Computer and Criminal History databases by PCSOs Jennifer Carmichael and Gillian McLeod. There is nothing to suggest the SiD or iVPD systems were interrogated.

[31] Constables Rana and Johnston gave PCSOs Marrone and Gildea four pieces of paper belonging to Mr Berry, which included his NHS prescriptions dated 25 June 2020 for lamotrogine, ibuprofen and co-codamol. While being processed Mr Berry was uncooperative and required assistance to stand straight. For the purposes of evaluating and managing risk, a careful and structured assessment must be made of every

individual prisoner's level of risk to their own safety and to that of staff and other prisoners. This is an ongoing process which should continue throughout the whole custody episode. Initially, police staff were unable to properly assess Mr Berry's level of risk. He refused to engage and was intoxicated, so the vulnerability assessment could not be completed. Part of the interaction involved him shouting "help", asking for a doctor and saying that he took fits. Police Sergeant McGhee determined he required a "high" level of supervision and placed him on Level 3 "constant observations", which required a member of staff to constantly monitor him via CCTV and to physically check on him at least once every 60 minutes.

[32] At 2317 hours Police Sergeant McGhee authorised a "strip search" of Mr Berry due to his refusal to engage. He was taken into Cell 16 and strip searched by PCSO John Boyd in the presence of Constables Rana and Johnston. The following items were logged by police staff as Mr Berry's personal property on the NCS:

a. Training shoes

b. Jogging bottoms

c. Harmonica

d. Lighter pen

e. Money to the value of £31.55

f. Four sheets of "PERSONAL PAPERS"

The "PERSONAL PAPERS" were logged incorrectly and should have been described in the free text section of the NCS as the prescriptions for ibuprofen and co-codamol and for lamotrigine.

[33] There were discrepancies in the recording of cell visits to Mr Berry on 10 and 11 July 2020. A PCR was brought with Mr Berry when he was initially taken to his cell. By the time it was made available, three visits had been carried out which were not recorded on the PCR and only one was recorded on the NCS: at 2346 hours PC Rana conducted a check which was not recorded on the NCS or the PCR; at 0002 hours PCSO Boyd conducted a check which was recorded on the NCS as occurring at 2358 hours and is not recorded on the PCR; and at 0022 hours PCSO Boyd conducted a check which was not recorded on the NCS or the PCR. On the PCR there were 15 recorded visits to Mr Berry: at 0110 hours, 0204 hours, 0302 hours, 0405 hours, 0501 hours, 0550 hours, 0630 hours, 0730 hours, 0740 hours, 0832 hours, 0930 hours, 1042 hours, 1050 hours 1139 hours and 1218 hours. The response provided by Mr Berry on each occasion is also recorded. On the NCS there are 14 recorded visits to Mr Berry: at 2358 hours, 0110 hours, 0205 hours, 0305 hours, 0405 hours, 0501 hours, 0550 hours, 0628 hours, 0638 hours, 0730 hours, 0740 hours, 0830 hours, 0930 hours, and 1042 hours.

[34] CCTV footage from the custody suite at Govan Police Office shows there were 21 visits to Mr Berry in total: at 2346 hours, at 0002 hours, 0022 hours, 0108 hours, 0110 hours, 0205 hours, 0304 hours, 0407 hours, 0502 hours, 0550 hours, 0556 hours, 0629 hours, 0730 hours, 0739 hours, 0802 hours, 0833 hours, 0938 hours, 1042 hours, 1047 hours, 1057 hours and at 1139 hours. From this footage it is clear that four visits took place beyond the 60 minute prescribed by the Police Custody Standard Operating Procedure: 0407 hours (63 minutes), 0730 hours (61 minutes), 0938 hours (65 minutes) and 1042 hours (64 minutes).

[35] On 11 July 2020 at 0502 hours, PCSOs Boyd and Marrone conducted a cell visit during which Mr Berry was observed as being under the influence of substances and said that he needed to see a doctor for a trapped nerve. This information was recorded on the PCR, but not on the NCS. No action was taken to refer him to a Health Care Professional (HCP). On 11 July 2020 at 1050 hours, the vulnerability assessment was completed by Police Constable Richard Duthie with Mr Berry in Cell 16. Mr Berry indicated: that he suffered from seizures, but was unsure if they were due to withdrawals or a medical condition; that he was prescribed medication to take twice daily for the seizures but was unsure of the name; and that he suffered from a trapped nerve for which he was prescribed co-codamol twice daily. These medical conditions were brought to the attention of Robbie Kane, Nurse Practitioner at the NHS Hub, Govan Police Office at around 1115 hours. The Care Plan was updated to reflect Mr Berry's medical condition at that time. Constable Duthie recommended that observation levels should remain the same and ordered Mr Berry be seen by an HCP. He observed Mr Berry clearly struggling with back pain.

[36] Various officers were responsible for monitoring Mr Berry in Cell 16 by remote CCTV. Between 2312 hours and 0235 hours on 11 July, Police Constable Daryl Johnston undertook observations. Mr Berry was sleeping whilst sitting on the toilet and then moved to the bed. He was checked routinely by custody staff and was fully responsive, lifting his head and looking at them whilst answering. Between 0225 hours and 0450 hours Police Constable Matthew Lloyd undertook observations. Mr Berry was asleep. Between 0450 hours and 0625 hours PCSO David Keltie undertook observations

of Mr Berry and two other prisoners. Mr Berry was sleeping and at one point, without getting up, adjusted his clothing.

[37] Between 0630 and 0700 hours and then from 0715 hours until Mr Berry was found unresponsive, PCSO Kenneth McCann undertook observations of Mr Berry. During this period PCSO McCann initially monitored three, then four prisoners. The screen then in place in the CCTV observation room could show images from four cells simultaneously in a quartered screen format which reduced the overall size of each image. The CCTV feed contained no sound. PCSO McCann did not maintain constant observations at various points in time. Between 06.35.46 and 06.35.53 hours he was at the observation room door, stepped part way out, looked up the corridor to the cell area and stood back into the room. Between 08.04.37 and 08.06.01 he was at the observation room door, looked right and left the observation room, entered the kitchen and then returned to the observation room. Between 08.39.22 and 08.39.49 hours he was at the observation room door with a cup in hand, looked down the corridor then walked to and entered the kitchen, then returned to the observation room. At 08.40.49 hours he was at the observation room door, looked right and then returned to the observation room, being absent for a period of 8 seconds. Between 08.48.05 and 08.48.17 hours he was at the observation room door, turned right along the observation corridor towards the cell area and then left to the kitchen, through the door to the kitchen corridor, about-turned and returned to the observation room. Between 08.53.10 hours and 08.53.56 hours he was at the observation room door, stepped out of the room looked right, turned left and slowly walked along the corridor to the kitchen door and entered,

before exiting carrying an object in his right hand and returning to the observation room. At 09.48.06 hours, he was at the observation room door, stepped out, looking right up the corridor toward the cell area, waited for a moment and then returned to the observation room before standing in the doorway with his back to the door, being absent for 8 seconds.

[38] At 1126 hours PCSO McCann was in the observation room and had been monitoring prisoners for a period of almost 5 hours with no official rest periods. CCTV footage from Cell 16 shows Mr Berry having a seizure at around 1126 hours on 11 July 2020. It lasted for approximately 3 minutes. He rolled onto his left side. His right arm and both legs can be seen to jerk and stiffen. His whole body then began to jerk and spasm. He rolled over face down, and the jerking and spasms slowed until he was completely motionless. He remained face down, uncovered by the blanket.

[39] At 1139 hours, Mr Berry was found unresponsive in Cell 16 during a welfare check by PCSOs Craig McBryde and Craig Walters, with his legs nearest the cell door, head towards the back of Cell 16 and lying face down. PCSO McBryde entered the cell and shook Mr Berry's right shoulder whilst asking him if he was ok. He received no response. PCSOs McBryde and Walters used the blanket to roll Mr Berry onto his back whilst keeping control of his arms. Mr Berry did not respond to their touch. PCSO McBryde manoeuvred Mr Berry into the recovery position and observed phlegm in his beard. Mr Berry was cold to the touch and there was clear liquid running from his nose. PCSO McBryde moved Mr Berry onto his back, checked to see if he was breathing but could not see his chest rising and falling. Police Sergeant

Jennifer Sneddon arrived at the cell. She and PCSO McBryde alternated doing rounds of 30 chest compressions on Mr Berry. After the third round, Nurse Kane entered the cell and attached the defibrillator to Mr Berry. His heartbeat was asystolic and the defibrillator recommended that no shock be administered. Nurse Kane commenced chest compressions until paramedics arrived.

[40] Paramedics Alan Dunn and Eilidh Jamieson arrived at 1152 hours. Nurse Kane was performing chest compressions upon Mr Berry at that time. Alan Dunn, the clinical lead, inserted an I-O (intraosseous) needle into Mr Berry's lower right leg and administered adrenaline. Paramedics Daniel Haxton and Katie McGratton arrived at 1157 hours. Alan Dunn intubated Mr Berry, put him onto "auto-pulse" – a mechanical CPR device – and allocated tasks to his four colleagues. For 22 minutes the medical staff administered advanced life support to Mr Berry. Katie Campbell carried out chest compressions and Eilidh Jamieson took charge of operating the bag valve mask and the defibrillator. Daniel Haxton gained intravenous access and cannulated Mr Berry's left arm in order to administer boluses of cardiac drugs. Mr Berry remained asystole throughout, except for one short period of ventricular fibrillation, which was the result of a shock being applied. Alan Dunn declared life extinct at 1218 hours.

[41] Following Mr Berry's life being pronounced extinct, he was left within cell 16 and the cell was secured pending scene examiner protocols being instigated. A Crime Scene Manager took photographs of Cell 16 on 11 July 2020, with Mr Berry still *in situ*, as well as other areas, including the cell corridor, the Prisoner Custody Record, and the exterior of the cell. Mr Berry was visually examined, and it was noted that he had

several minor cuts and bruises across his upper body. He was thereafter removed to the mortuary at the Queen Elizabeth University Hospital to allow for a post-mortem examination to be conducted. On 20 July 2020 PIRC Investigators Maurice Rhodes and James Wallace attended at Govan Police Office. They were given access to the Observation Room within the custody suite used by PCSO McCann on 11 July 2020. James Wallace took photographs of the general view of the room.

[42] A post-mortem examination was carried out on Mr Berry on 5 August 2020 by Dr Julia Bell, Forensic Pathologist. Mr Berry's cause of death was identified as;

1 Seizure related death due to

1b Epilepsy and cardiac enlargement with myocardial fibrosis

2 Chronic alcohol abuse

The conclusions contained within the post-mortem were:

> "This 50 year old man had a history of epilepsy and alcohol related seizures. Epilepsy can be associated with sudden unexpected death (sudden unexpected death in epilepsy or SUDEP) and typically there are no specific findings at post-mortem examination to confirm it and it is diagnosis of exclusion. The definition of SUDEP is 'sudden unexpected, witness or unwitnessed, non traumatic and non drowning death in patients with epilepsy, with or without evidence for a seizure and excluding documented status epilepticus, in which post mortem examination does not reveal a toxicological or anatomical cause for death. It is not certain as to the mechanism of death in these cases, however, it is thought that the seizure activity interferes with the heart rate and breathing control centres within the brain and that this can lead to cardiac arrest. As its often the case in seizure related death, neuropathological examination of the brain revealed no significant abnormality.
>
> In terms of other natural disease, [Mr Berry] was also unexpectedly found to have a large heart. The heart weight was significantly above the normal range for a man of his size (weight 570g, range 23.1 – 463.8g). this enlargement was associated with concentric left ventricular hypertrophy and a common cause of this is chronic high blood pressure. Microscopic examination of the heart muscle

> also revealed mild scarring (myocardial fibrosis). This extent of cardiac disease was such that sudden death could have occurred at any time, due to arrhythmia.
>
> Given that [Mr Berry] had a significant witnessed seizure with subsequent unconsciousness and cardiac arrest, it would therefore suggest that epilepsy/seizure have been a main factor in his death but the presence of heart disease was probably also significant as it may have made him more susceptible to a seizure related cardiac arrest.
>
> [Mr Berry] also had a history of chronic alcohol abuse and, in keeping with this, the liver showed fatty change and mild scarring. Chronic alcohol abuse can also be associated with seizures – it was noted that [Mr Berry] had a history of this – and these can often occur during period of withdrawal. It therefore also has a potential role in his death. He had no other significant natural disease.
>
> Given the history, toxicological analysis was also performed. This detected a low level of alcohol in [Mr Berry's] blood along with Lamotrigine (his prescribed anticonvulsant). Dihydrocodeine and codeine were also present in urine. Caution should be taken when comparing concentrations in post mortem blood samples with reference plasma and serum ranges, as distribution of the drug can vary between sample types. The therapeutic serum concentrations for Lamotrigine are in the range of 2-15mb/l. The level detected in this case was 1.9mg/l, at the lower end of the therapeutic range.
>
> ....
>
> In summary, [Mr Berry] has had a seizure related death on a background of epilepsy and cardia enlargement with myocardial fibrosis. He also had a history of chronic alcohol abuse which was probably also a contributory factor in his death."

<u>Issues arising from deaths of Declan Gallacher and David Berry</u>

Declan Gallacher strip search

[43] In relation to prisoner searches, the Police Scotland Care and Welfare of Persons in Police Custody Standard Operating Procedure (SOP), in place at the time of Mr Gallacher's death in December 2018 (version 13), stated:

"12.1.1. It is the responsibility of the Custody Supervisor, custody staff and arresting/escorting officers to ensure that all prisoners are subject to a through and methodical search…

12.1.3. The primary purpose in searching prisoners is to ascertain and record everything a person has with him/her when brought to the custody centre and to remove any articles that:

- May be used by the prisoner to harm himself/herself or others,
- May be used to aid escape or cause damage,
- Requires safe keeping,
- Is evidence.

12.1.4. Before conducting a search, officers must explain their intended actions to the prisoner.

12.1.5. Male prisoners are to be searched by males and female prisoners are to be searched by females. Where the search is to go beyond a normal search of clothing, it is to be conducted in private, away from the charge bar…

12.1.7. Where available custody trained staff should perform the searching to ensure consistency…

12.1.10. Both the extent and location of the search are decided by the Custody Supervisor, who should take into account all the relevant information available. There are three levels of search available, namely:

- Standard search
- Strip search
- Intimate search

12.1.11. Where the Custody Supervisor decides that a strip search or intimate search is necessary, the reasons and justification for this must be recorded on the National Custody System. If a strip search is carried out it must be authorised by an officer holding the rank of at least Sergeant…

12.3 Strip Searching

12.3.1. Strip search is the removal and examination, in stages, of all clothing, with a visual, external examination of the body…

12.3.2. Where it is decided that the prisoner should be subject to a strip search, the reason for this should be recorded on the National Custody System. The

> name of the authorising officer, of at least the rank of Sergeant, should also be included…
>
> 12.3.3…The following should thereafter be followed:
>
> - The reason for the search must be fully explained to the prisoner…"

[44] PCSO MacInnes carried out a standard search on Declan Gallacher at the charge bar area during processing. A number of items were removed from him, itemised and logged on the NCS as his personal property. A standard search involves a search of the full body length of a clothed individual, including waistbands, pockets, socks and shoes. Such a search is carried out on every person taken into police custody. This can be contrasted with a strip search which takes place in a cell and involves the individual removing their clothing and being searched, including areas where items may be secreted, such as armpits, toes, soles of feet and posterior. The SOP in place at the time of Mr Gallacher's death made clear that a strip search was to be authorised by an officer of the rank of at least Sergeant, and that the reasons had to be recorded on the NCS. The NCS includes a section for officer notes as well as a drop down menu, which allows the level of search authorised to be recorded. Sergeant McKenzie noted on the NCS that a strip search was to be carried out on Mr Gallacher due to the risks related to his drug use, including the concealment of drugs. The drop down menu to record this level of search was however recorded as a "standard" search. A strip search was not carried out on Mr Gallacher. CCTV footage from within his cell at 0206 hours shows his hand moving from his trousers and then to his mouth. However, there was no evidence to

suggest he ingested drugs at this point nor any submission from parties that I should so find.

[45] The evidence as to when and how the decision to conduct a strip search was communicated by Sergeant McKenzie was unclear. Having viewed CCTV footage from the charge bar area, Sergeant McKenzie identified a point in time where he believed he quietly told PCSO MacInnes to do it as the latter was moving from the charge bar to conduct the standard search. His reason for communicating it in this manner was to avoid inflaming the situation. PCSO Campbell stated that some prisoners "kick off" when told they were to be strip-searched. PCSO MacInnes was unsure if an instruction to strip-search had been given to him. Once Mr Gallacher was removed from the charge bar area, Sergeant McKenzie asked PCSO Campbell if the strip search was taking place. PCSO Campbell responded "they're searching him the now aye". The SOP in place at the time, and now, make clear that the reasons for the strip search being carried out should be fully explained to a prisoner. Police Inspector Gunn's position was that he would inform a prisoner of this to avoid any dubiety and that compliance can usually be obtained with some explanation. He suggested that some guidance and support on this subject, perhaps through nationally circulated memos, might assist.

[46] On the evidence, the method by which the strip search is recorded on the NCS is not straightforward. Reference was made in evidence to a "linear path" in which fields and information have to be completed sequentially. In practice, this meant that "standard search" would initially be selected from a drop down menu to allow the field recording a prisoner's property to be completed. Thereafter, the search level can be

changed to record the strip search on the drop down menu. If the level was set to "strip" initially, the system would not allow officers to progress to the next screen until the outcome of the strip search was entered. PCSO Campbell suggested at one stage that it was not possible to move backwards along the linear path to change the search level entry. That is not correct on the evidence presented at the Inquiry. Nevertheless, the system as presently designed is cumbersome and leaves room for some confusion or error. That was the position of Sergeant McKenzie. Inspector Gunn indicated that the system would be more user friendly were it to be modified to allow the selection of strip search from the outset, while still allowing the option of a prisoner's property to be recorded before the strip search outcome is completed.

[47] There were errors made in the search of Mr Gallacher. There are also shortcomings on the NCS system for recording searches. Nevertheless, I conclude that there is no evidence that any precautions which might reasonably have been taken surrounding the strip search might realistically have avoided death in the circumstances of Mr Gallacher's case. Nor is there evidence to justify the conclusion that any defects in the system of working associated with the search entries on the NCS contributed to his death. My reasons for this are outlined further below when I consider the medical evidence.

[48] However, I consider that there are possible improvements in the system of working by which the police record searches. In this case, there was evidence that a strip search of Mr Gallacher ought to have taken place, but did not. If this were to happen in other cases, it would be a clear risk. As highlighted by Inspector Gunn,

where a strip search has been ordered it is critically important that it is properly conducted. His suggestion that Police Scotland might wish to issue some guidance within the Criminal Justice Division as to how to confidently and appropriately inform a prisoner that such a search is to take place seems to me to be sensible. However, the extent to which this assures that strip search actually takes place is limited.

[49] A system of recording on the NCS with appropriate mandatory fields would increase the chances of the correct procedure being followed in every case. The submissions on behalf of the Chief Constable suggest that as a standard search would always precede a strip search the first entry of "standard" is required as not all prisoners require a strip search. I am not convinced of the logic of that contention: if every prisoner is subject to a standard search the fact that this has taken place is what ought to be recorded in every case as well as the property recovered. However, the selection of "standard search" as an option is redundant: it is to take place in every case. Logically it seems more prudent for the strip search option to follow on a separate section on the linear path, perhaps through a yes/no field, with the reasons thereafter being required. It would also assist if the NCS had a field to confirm that the decision for the strip search, and the reasons therefore have been communicated both to the prisoner and to the officer being asked to conduct the search. This would limit the officer moving on from those entries until the decision has been made, intimated and recorded. If this ensures that some strip searches take place that would otherwise be missed, it might realistically prevent deaths in similar circumstances. A development review of the NCS is currently taking place, but the position of the Chief Constable is

that any change to the linear path is likely to be given low priority. I recommend that this change be considered as an appropriate matter to be considered under the review.

Processing of prisoners on Police National Computer

[50] The evidence presented at the Inquiry made clear that the processing of prisoners is a crucial stage in their detention. DI Nicolson was clear that the process can take time and that care has to be taken. Part of the process involved asking prisoners a number of "vulnerability questions" which are then recorded on the PNC. The answers to these questions are an important part of the Risk Assessment for the Care Plan which is produced for each prisoner in police custody, setting out, among other things, the level of any observations required. As DI Gunn made clear, officers also have to rely on their experience to assess the truthfulness of any answers given to the vulnerability questions. Risk is assessed with the formula Risk = (Threat + Vulnerability + Severity) x Likelihood. Errors were made in the processing of Mr Gallacher at Clydebank Police Office and Mr Berry at Govan Police Office.

[51] In relation to Mr Gallacher, the answers to the vulnerability questions were not completed as fully as they ought to have been. In particular, when Mr Gallacher was asked whether or not he had taken any drugs or psychoactive substance in the previous 24 hours he initially said no. That was recorded on the NCS. However, as the process continued, he made clear that he had in fact taken Xanax. That matter having been clarified, the answer to that question ought to have been updated on the NCS, but that did not happen. PCSO Campbell, who was responsible for completing the NCS entries,

indicated that the "linear path" system of the PNC did not allow answers to be changed. However, I do not accept that explanation. Evidence of the system in operation was presented which showed that such changes were possible. Moreover, DI Gunn gave evidence that more information ought to have been asked of Mr Gallacher when he confirmed previously suffering withdrawal symptoms from Xanax or Valium: he ought to have been asked when he last took such a drug, what the signs of withdrawal were, and what happened during a withdrawal. The answers ought then to have been recorded in the NCS free text section. This was not done.

[52] The precaution of fully and accurately completing the NCS is one which might reasonably have been taken. However even without them having been taken, the decision by Sergeant McKenzie was still to place Mr Gallacher on constant observations at Level 3 and deem him a "high risk" due to his history of seizures. Mr Gallacher's custody notes recorded the fact that he suffered seizures due to withdrawal and that he last had one 6 weeks prior to his arrest. For these reasons, and for the reasons set out further below in relation to the medical evidence presented, had the precaution been taken I do not find that it might realistically have resulted in Mr Gallacher's death being avoided.

[53] In relation to Mr Berry, as noted earlier, there is nothing to suggest that any checks were carried out in relation to him on the Scottish Intelligence Database and Vulnerable Persons Database sections of the PNC. A check of the NCS would have shown Mr Berry's seizure history, as he had told police custody staff of his seizures on six previous occasions. It was agreed between parties that it was incumbent on custody

staff to carry out those checks prior to Mr Berry being presented at the charge bar. No explanation was presented in evidence as to why these checks did not take place in Mr Berry's case. It is clear from the evidence that there is in place a system of working designed to ensure these checks take place, with officers being provided with a sheet of paper to fill in the details of such checks prior to a prisoner being presented at the charge bar. The NCS provides a free text area for the results of the checks to be entered onto the system.

[54] Inspector Nicolson suggested that the NCS should have mandatory fields to ensure that all areas of the database are confirmed as having been checked individually to ensure information is not missed. That would seem to be a sensible precaution to take. Mandatory fields in the NCS would prevent an officer from moving on until it is confirmed whether these databases have been checked. Where system checks might disclose a medical history such as seizures or self-harm, it would also appear to be an improvement to the Police Scotland's system of working which might realistically prevent other deaths in similar circumstances. I recommend that this change is implemented. The precaution of checking these systems is one which obviously ought to have been taken at the time. However, Mr Berry himself mentioned his seizure history. As noted below, its existence would not have altered the monitoring regime chosen by Sergeant McGhee, but may have led to Mr Berry being referred to the HCP sooner. For the reasons set out further below, when considering the medical evidence, I do not consider there to be evidence that, had it been taken, it might realistically have resulted in Mr Berry's death being avoided.

[55] A further issue identified concerned the ability of the PNC to adapt to the specific Care Plan put in place by the custody supervisor. Specifically, an entry placing a prisoner on Level 3 constant observations automatically defaults to a rousing and visiting regime of 60 minutes. It does not allow more frequent visits to be set. As highlighted by both Inspectors Gunn and Nicolson this is unhelpful, as it may be the case that more frequent visits are required depending on the specific vulnerabilities of individual prisoners. A "work-around" has been found which allows more frequent visits to be set by entering these at the Level 2 observations screen, even where the prisoner is on fact on Level 3 observations. This system of working seems confused. The level of observations of prisoners and the frequency of visits are clearly of critical importance in preventing harm. Confusion about such matters risks the Care Plan being put in place for a prisoner not being properly implemented. Inspector Anthony Fitzpatrick, from Police Scotland's Contact, Command and Control Division, has indicated that this issue has been identified and escalated for possible resolution, but at the moment it does not appear to be a priority. I consider that confusion around Care Plans and visit regimes could result in harm to prisoners. A change to the system of working to fix this system issue might realistically prevent deaths in other circumstances. I recommend this be done.

[56] The processing at the charge bar of Mr Berry was carried out by PCSO Marrone. She was relatively new to the role and so was working under the supervision of PCSO Gildea. The CCTV footage showed Mr Berry repeating the word "help" several times and mentioning that he took fits and seizures. Neither of these matters were

noted on the observations section of the NCS during processing. The SOP in place at that time made clear that that any observations about the demeanour and state of a prisoner ought to be noted. PCSO Marrone accepted in evidence that, with hindsight, both these observations ought to have been recorded on the NCS. Mr Berry was noted on the NCS as being "heavily intoxicated" and "unable" to complete the questions to allow a care plan to be formulated. Inspector Nicolson indicated that the decision to place Mr Berry on Level 3 constant observations was correct, but that she considered rousings every 15 minutes to be appropriate. However, the evidence on the appropriate rousing interval was less clear. Inspector Gunn was not as clear that such a frequent period would be appropriate, and, in any event, the evidence suggested that this is always a matter for the custody supervisor taking into account all of the circumstances. In any event, as noted above, Mr Berry was later able to complete the vulnerability questions. In the circumstances I do not find that more frequent rousing periods was a precaution which, had it been taken, might realistically have resulted in Mr Berry's death being avoided.

[57] Mr Berry's prescriptions were passed to PCSOs Marrone and Gildea. At the time PCSO Marrone did not know what lamotrigine was prescribed for. As indicated earlier, the prescriptions were simply recorded as "personal papers" on the NCS. With hindsight PCSO Marrone accepted that the existence of the prescriptions ought to have been recorded separately, and that the team leader or custody sergeant should have been informed of them. She thought that she had made Sergeant McGhee aware of their existence, but could not recall if she had told him about Mr Berry taking fits and

seizures. Sergeant McGhee indicated that he could see and hear to a degree what was happening at the charge bar through his office window. He could not recall being told that Mr Berry took fits and seizures or about the prescription for lamotrigine. He indicated it would not have affected his decision as regards Mr Berry being placed on a constant observation regime: his intoxication and failure to answer vulnerability questions were the important factors in Mr Berry being placed on constant observations. He would however have made sure the HCP was notified sooner, and briefed those observing Mr Berry that he may have had a health condition given what he had been prescribed. He indicated that it was not uncommon for prisoners to present with undispensed prescriptions. The process for dealing with that could have been clearer had training been provided. A prescription for lamotrigine was one which ought to have been notified to the HCP. The precaution of noting these issues on the NCS and ensuring that the custody supervisor or sergeant were aware of them is, again, one which obviously ought to have been taken. This failure is linked to the question of whether a referral to a HCP ought to have taken place sooner, which is considered below. Again, for the reasons set out further below, I do not consider there to be evidence that, had this precaution been taken, it might realistically have resulted in Mr Berry's death being avoided.

[58] On the evidence there were also issues regarding the system of working in the recording of prescriptions which might have been open to improvement. However, the evidence also made clear that steps have already been taken in this regard. Following Mr Berry's death, an e-brief was issued to all staff making clear that in such cases the

HCP should be made aware and that the custody record should be updated accordingly. In addition, Inspector Nicolson recommended that the SOP be updated to reflect the fact that a custody supervisor should be informed if a prescription or medication is found during a prisoner search. The current SOP now makes clear that any prescription or medical document must be documented on the NCS, and brought to the attention of the HCP by the custody supervisor and made available for examination. Given that this improvement is already in place, I have no further recommendations to make in this regard.

Cell visits to Declan Gallacher and David Berry

[59] As indicated at para [34] above, four of the cell visits to Mr Berry took place beyond the 60 minute prescribed by SOP in place at the time: 0407 hours (63 minutes), 0730 hours (61 minutes), 0938 hours (65 minutes) and 1042 hours (64 minutes). The precaution of ensuring these checks were carried out on time is one which ought to have been taken. However, even had this been done, no evidence was presented suggesting that it might realistically have resulted in the death of Mr Berry being avoided. As set out at para [34] above, numerous cell visits to Mr Berry did take place after 1042 hours that were within the 60 minute prescribed period. Discrepancies in the recording of cell visits to Mr Berry on the NCS as compared to the PCR are noted at para [33] above. Improvements to the system of working in relation to the recording of cell visits are considered further below.

[60] In relation to prisoner visits, the respective SOPs, versions 13 and 15, in place as at the time of Mr Gallacher's death and Mr Berry's death , stated:

> **"15.1 Prisoner Cell Visits**
> 15.1.2. Every prisoner should undergo a care and welfare assessment before they are placed in a cell. The assessment will determine a suitable care plan which is proportionate, necessary and justified.
>
> **15.2 Frequency of Visits**
> 15.2.1. There are four levels of monitoring and visits which can be used…
>
> - **Level 3** – Constant (Harm Awareness) Observations
>
> The prisoner is under constant observations. Constant observations may be achieved by:
>
> (a) CCTV monitoring stations, or
> (b) Glass cell door, or
> (c) Window observation cells, or
> (d) Through open cell hatches.
>
> Visits can be conducted and recorded at 15, 30 or 60 minute intervals…
>
> **15.4 Nature of Visits**
> 15.4.1. As a minimum all prisoners are to be visited at least once per hour unless they are under a level 3 or 4 observations regime…
> 15.4.3. The use of technology does not negate the need for physical visits.
>
> **15.5 Verbal Response**
> 15.5.1. A clear verbal response should be obtained during each visit unless an unobtrusive visit is being performed and the prisoner is sleeping…
> 15.5.3. The majority of prisoner visits can be conducted from an open hatch but when a prisoner cannot be roused or spoken to, the cell should be entered and their welfare confirmed.
> 15.5.4. All prisoners are to be visited at least once per hour...
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> **15.7 Recording of Visits**
> 15.7.1. Every visit made to a prisoner **must** be recorded on the relevant Prisoner Contact Record (PCR). A distinct verbal response must be sought from the prisoner during the course of the visit which should be noted accurately on the PCR.

> **Note**: If the custody centre has less than five cells a PCR will not be used and the recording of visits will be completed within the custody record."

[61] On the evidence presented, the cell visits to Mr Gallacher were not carried out in accordance with SOP then in place. Mr Gallacher was placed in his cell at 0158 and given a cup of water and cereal bar by PCSO MacInnes through the hatch of the cell at 0200 hours. For convenience, hourly cell visits to prisoners were conducted at the same time as each other, even if prisoners in any particular cell had been there for less than an hour. A cell visit to Mr Gallacher was conducted at 0230 hours by PCSO Campbell. He did not attempt to obtain a verbal response from Mr Gallacher, who appeared to be asleep, and he did not enter the cell to confirm Mr Gallacher's welfare. The check was not carried out through an open hatch to the cell, but through a smaller window to the side of the hatch. A further visit to Mr Gallacher's cell ought to have taken place by at least 0330 hours. This did not happen. Despite this, an entry was put through on the NCS by PCSO Campbell, recording that such a visit had taken place.

[62] PCSO Campbell accepted not following the SOP. He stated that the SOP did not reflect the reality of working in the custody suite and that the SOP was not routinely followed in all aspects. His reasoning for failing to confirm a verbal response during the 0230 hours cell visit was that Mr Gallacher was under constant observations, and that any concerns about his welfare would therefore have been relayed by the monitoring officer. He was also aware that Mr Gallacher had only been in the cell for 30 minutes. As regards the failure to conduct the check at 0330 hours he indicated that staff were "juggling balls" and had to check on around 29 cells. He carried out all of the

checks, excluding Cells 1 – 4. He recalled someone being processed for a drink driving offence at around that time and said that he was required to assist, as PCSO MacInnes was not familiar with that process. He filled in the entry for all of the cells, planning to tell PCSO MacInnes to carry out the remaining cell checks.

[63] The explanations provided by PCSO Campbell did not accord with evidence I accepted. The CCTV footage from the charge bar at 0347 hours showed that it was actually PCSO MacInnes who asked whether the 0330 hours cell checks had taken place. Only then did PCSO Campbell mentioned that Cells 1 – 4 had not been checked. PCSO MacInnes spoke to processing the drink driving offender. There was no other evidence of the custody suite being excessively busy. In any event, as both Sergeant McKenzie and Inspector Gunn stated, the cell checks should take priority in that situation with prisoner throughput being paused. Those waiting, being with arresting officers, did not present the same risk. There was no evidence of a culture of cell visits being recorded despite no cell visit. Indeed this was accepted by PCSO Campbell. The overwhelming evidence was that PCSO Campbell ought to have obtained a verbal response from Mr Gallacher. This was expected practice, it featured in training, and the SOP, of which PCSO Campbell was aware, was clear. My conclusion is that the failure in the nature and timing of the cell visit was not systemic, but an individual error. The precaution of carrying out the checks in accordance with the SOP ought to have been taken. However, for the reasons set out further below when considering the medical evidence, I do not consider there to be evidence that, had it been taken, it might realistically have resulted in Mr Gallacher's death being avoided.

[64] As recorded at paras [17] and [33] to [34] above, there were discrepancies in the recording of cell visits to both Mr Gallacher and Mr Berry. These discrepancies were more indicative of a systemic issue. At the time of each death, cell visits were recorded on both the PCR outside the relevant cell, and on the NCS. There was evidence that this dual entry procedure was apt to cause confusion which might, in part, account for these discrepancies. The recording of health issues or other vulnerabilities of prisoners is clearly essential in determining the observation regime and whether they ought to be referred to an HCP. In the case of Mr Berry, the position of PCSO Gillian McLeod, a team leader in the custody suite at the time, was that she was not made aware that during the cell visit at 0502 hours he requested a doctor due to a trapped nerve. This request was recorded on the PCR but not the NCS. Had she been aware, she would have requested further information be taken from a prisoner before contacting an HCP. The issue of whether contacting an HCP earlier in respect of Mr Berry was a reasonable precaution which might realistically have resulted in his death being avoided is considered further below.

[65] Police Scotland has taken action in relation to the systemic issues identified. Following the death of Mr Gallacher it issued a memorandum making clear that the practice of one officer carrying out a cell visit while another updated the system was to stop immediately. Audits of NCS entries and reviews of CCTV take place daily to identify practices not in accordance with the SOP. Following the deaths of Mr Berry and Mr Gallacher, a single entry system was introduced with the only entry being recorded on the NCS. There is no longer any entry made on a PCR. For a time

electronic tablets were introduced to allow for a "real time" remote updates to the NCS. However, there have been health and safety concerns as well as technical difficulties. At the time of this decision, they are not being widely used. Nonetheless, Police Scotland are undertaking further project work to identify a further digital solution. In the circumstances, standing the work already being carried out, I have no recommendations which might add to the solutions being worked upon to this system of working.

Constant observation

[66] The evidence presented at the enquiry suggested both individual errors and systemic issues were present in relation to the constant observation by CCTV monitoring of both Mr Gallacher and Mr Berry.

Guidance and regime in place at time

[67] The versions of the SOP in place at the time of the deaths of both Mr Berry and Mr Gallacher provided guidance in relation to officers carrying out constant observations on prisoners via CCTV. They made clear that the custody supervisor was to brief the observing officer to ensure they were suitably experienced, fully aware of their role, and that vigilance was observed at all times including particularly in relation to self-harm. They highlighted, in particular, that under no circumstances was the observing officer to be distracted by other tasks while observing. The officer was to be dedicated solely to the constant monitoring of the prisoner. They stated that

"consideration must be given to relieving the officer undertaking the observations on a regular basis". They confirmed that constant observations did not negate the need for a regime of cell visits to be put in place. They also made clear that an entry to the prisoner's custody record had to be made detailing, among other things, the reason for constant monitoring, the person conducting the observations and that a briefing was provided.

[68] In addition, the versions of the SOP then in place stated that a document set out in Appendix I to the SOP entitled Guidance for Officers Engaged in Constant Observations of Prisoners was to be available and displayed in every custody centre. Appendix I took the form of an "aide memoire" to observing officers. It highlighted that the reasons for placing a prisoner on constant observations "include" a high risk of suicide, drugs or other items concealed internally, or them being apprehended for a "grave crime". No mention was made of concerns about withdrawal or seizures. It made clear in a list said to be "non-exhaustive": that the responsibility for the prisoner's care and welfare lay with the observing officer; that they should remain alert at all times to any changes in the prisoner's demeanour or state of intoxication; that they should ensure a prisoner's head and shoulders were always visible above any blanket; that if the prisoner were suspected of concealing items internally, that the prisoner's hands be visible at all times; that officers were not to carry out any other duties such as report writing; that if carrying out observations on more than one prisoner, officers were to alert staff in relation to any incident and not leave to assist; and that, if they had any concerns, officers should alert custody staff. It highlighted, in bold, that if the

officer was in any doubt about any issue they should ask. Police Scotland also produced a poster for observing officers summarising this guidance and their duties.

[69] On 14 April 2020, following the death of Mr Gallacher, but before the death of Mr Berry, further operational guidance was issued to officers, to be read in conjunction with the SOP. It made clear that the briefing provided to the observing officer should include: the layout of the custody centre; details of the prisoner; a summary of the prisoner's risk assessment and care plan; specific behaviours which should be watched for; and the action to be taken in relation to any concerns. It made clear that staff on observing duties were to be relieved "on a regular basis", and that custody staff and local policing supervisors should "work closely" to ensure this took place. The observing officers were to be allowed breaks away from the observing area. They were not to carry out any other duties and should not use any mobile phones or electronic devices "in such a manner as to distract them from their core observing duties". The rotation of officers was to be recorded on the prisoner's record. Custody supervisors were to ensure observing officers were briefed and relieved on a regular basis. Observing officers were to make sure they understood the briefing and raise any concerns about the CCTV equipment or suitability of locations immediately with a supervisor.

Knowledge and training of officers conducting constant observations

[70] Both PCSO McCann and PC Duncan Whyte were familiar with the SOP in place at the time in relation to constant observations. PC Whyte could recall that Appendix I

was on display in the custody suite at Clydebank Police Office at the time of the death of Mr Berry, and that the poster summarising the duties of observing officers was on the wall of the custody suite. PCSO McCann thought that he may have seen Appendix I before, but could not recall if it was on display at Govan Police Office although there was photographic evidence that it was present. He could not recall seeing the poster summarising duties, but did recall a poster making clear that mobile devices were not to be used. PCSO McCann could not recall having seen additional written guidance issued in April 2020 when observing Mr Berry, but was familiar with much of what it recommended, describing some of it as common sense.

[71] At the time of both deaths there was no formal training for officers in relation to constant observations via CCTV. That remains the position today. Both PCSO McCann and PC Whyte spoke to learning through experience on the job, from discussions with colleagues about what it involved and from common practice. The evidence also suggested that there was no bank of officers specifically allocated to this role on any particular day: PCSO McCann's evidence was that he happened to be passing when he was allocated the duty. Both PCSO McCann and PC Whyte stated in evidence that they had not had any formal training in relation to recognising seizures. However, this did not accord with other evidence at the Inquiry and I consider that they may have been mistaken in their recollection. At the time of the deaths of both Mr Gallacher and Mr Berry, induction training was given to all custody officers. This included a section on the care and welfare assessment of prisoners, part of which is delivered by an experienced HCP. This section covered seizures and how to deal with them.

Additional first aid training in place and delivered in person at the time of both deaths provided further guidance on the identification and treatment of seizures.

Conduct of constant observations: Declan Gallacher

[72] PC Whyte was briefed on the prisoners who were in custody at Clydebank Police Station on 23 December 2018, including Mr Gallacher. He had conducted constant observations on a number of occasions previously, was aware of his responsibilities and felt confident undertaking the role. He knew, from experience, issues to monitor: he knew to watch for signs of someone being unwell, including through a seizure, and that that might include limbs shaking and moving. He was briefed on all of the prisoners he was monitoring in accordance with the SOP. In relation to Mr Gallacher he knew that he had suffered a seizure a few weeks before his arrest and that fitting or spasms were therefore things to look out for. At that time there was a whiteboard within the custody suite, but not the observation room, providing details on each prisoner in custody and any known risks.

[73] At the time of Mr Gallacher's death, the observation room in Clydebank police station had two monitors each with a screen size of around 19 inches. They had no zoom function to allow a close-up of any area within the cell and there was no audio to accompany the images. For the purpose of monitoring prisoners, the images on the screens were divided into quadrants. Each cell appeared on a single quadrant. At the time of Mr Gallacher's death, the monitors were on a night-time setting, which meant that there was a yellow tinge to the screen and the images being viewed were not in

colour. The lights in the room would reflect on the monitors at times. The size, resolution, and quality of the images made it difficult to pick out details. The screen units were separated by a partition wall, extending from a point between each screen to about halfway across the room. A seat was provided for any observing officer in front of each respective screen and any officers would be separated by the partition wall. When PC Whyte was asked to monitor the second screen, on which Mr Gallacher appeared, he had to move his seat to the edge of the partition wall and repeatedly look left and right to regularly monitor each screen in turn. He did not notice Mr Gallagher move his hand from his waistband to his mouth, nor see him suffer a seizure, nor see the vomit on his face or the floor.

[74] At the time PC Whyte was asked to take up observations on Mr Gallacher he had been observing prisoners for around 2 hours and 25 minutes. He had not been offered a break, although he believed his level of concentration was still good. The system for providing breaks to observing officers was opaque with no formalised regime. PC Whyte was aware from experience that he could shout through to other members of staff, should he wish a toilet break or to stretch his legs. If, as was the case for PC Whyte, the observing officer come from a different police office, any request for a longer break required him or her to arrange that with their local police supervisor: it was not within the authority of the custody staff to authorise.

Conduct of constant observations: David Berry

[75] PCSO McCann was briefed on the prisoners present in Govan Police Station on 11 July 2020. The briefing he received did not specifically cover all of the points set out in the SOP or the updated guidance, but he was aware of the pertinent issues and his responsibilities. He had conducted constant observations before and knew he required to conduct the observations without distraction, to look out for anything out of the ordinary in relation to prisoners, and to alert colleagues immediately should he make any such observation. The briefing he received, along with his colleagues, covered all the prisoners in custody that evening and any special needs or issues which they had. He was made aware that Mr Berry was on constant observations as he had been brought into the police office in a state of intoxication, had been unable to answer all of the vulnerability questions asked of him, and, therefore, that no care plan could be prepared. Had he been told that Mr Berry suffered seizures it may have affected his level of vigilance, but he knew vigilance was required for all prisoners under constant observations.

[76] At the time of Mr Berry's death the observation room in Govan Police Station was situated about 5 feet away from the communal kitchen. It had two monitors each with a screen size of around 32 inches. Again, the screens had no zoom function to allow a close-up of any area within the cell, there was no audio to accompany the images, and, for the purpose of monitoring prisoners, the images on the screens were divided into quadrants, with each cell appearing on a single quadrant. Again, this limited the extent to which observations could be undertaken. In Govan police station

there was a whiteboard in the observation room itself, and this had details of the prisoners being monitored and why they were being watched. There was no partition wall between the screens: each was placed on or above a desk, with both desks being placed side by side along with a chair for each observing officer. There was a sign making it clear that mobile devices were not to be used.

[77] During PCSO McCann's observations, colleagues entered the observation room on five separate occasions. In addition PCSO McCann left the observation room on the occasions set out at para [37] above, on a number of occasions. He was aware of his duties and could provide no explanation for this. During the time that Mr Berry was the subject of constant observations there were a number of points where, in contravention of the SOP the in place, his head and shoulders were not clearly visible above his blanket. No action was taken. PCSO McCann did not notice Mr Berry suffer a seizure when conducting observations. On seeing the CCTV footage during the Inquiry, he confirmed that, had he seen it, he would have contacted the duty officer. At 1126 hours, when Mr Berry was seen to be suffering a seizure on the CCTV footage, PCSO McCann had been on constant observations for almost 5 hours with no official rest period having been provided, and having only been relieved for a period of 15 minutes. He was referred to guidance suggesting a comfort break from constant monitoring could be requested for 5 minutes every hour, or 25 minutes every 2 hours. The status of this guidance was unclear from the evidence. It stated that custody staff would make "every effort" to accommodate a request "as soon as is practicable". PCSO McCann was unaware of this guidance, but knew he could request a break.

Conclusion on evidence about constant observations

[78] There are some obvious precautions which could have been taken in relation to the constant observations of both Mr Gallacher and Mr Berry. The most obvious is that PCSO McCann could have remained in the observation room while assigned this duty. In addition, he might have notified staff when Mr Berry's head and shoulders were not visible above his blanket, in accordance with the SOP then in place. The fact that he did not, and that he did not notice the seizure suffered by Mr Berry, allow the inference to be drawn that a further precaution which could have been taken was more vigilant monitoring of the prisoners under constant observations at that time by him. In relation to Mr Gallacher, a precaution which might have been taken was to assign a second officer to conduct constant observations with PC Whyte. He was left in the invidious position of having to watch prisoners who met the criteria for constant observations on two small screens separated by a partition wall. For the reasons set out further below, when considering the medical evidence, there was no evidence to show that, had these precautions been taken, they might realistically have resulted in the deaths being avoided.

[79] There were also potential defects in the system of working in relation constant observations. These related to the quality of the equipment, the regime in place in relation to breaks, the ratio of observing officers to prisoners and the training in place for officers. These issues are discussed further below, as well as improvements which have since been made by Police Scotland. However, again for the reasons set out

further below when considering the medical evidence, there was no evidence before me to show that any such defects contributed to either of the deaths.

[80] Since the deaths of Mr Gallacher and Mr Berry, Police Scotland have made a number of improvements to the equipment in the constant observation rooms in both Clydebank and Govan Police Offices. Clydebank Police Office now has 42 inch screens, with High Definition (HD) cameras with a zoom function installed in each cell. Lighting has also been improved in the monitoring room. Improvement works at Govan Police Office in relation to observations cells have been completed to Home Office standards. The CCTV system, including in-cell cameras, monitors and constant observations stations have all been upgraded. The number of observation cells has been increased and an additional viewing station added. Larger monitoring screens are in place, with zoom-capable HD cameras in all cells, and lighting arrangements are improved. Works have also been completed or are planned across all primary custody suites in Scotland. Whiteboards with the details of each prisoner being observed are now present in every observation room.

[81] It remains the case that there is no audio recording in relation to the images being monitored. The issue of whether it might assist to have such audio, particularly were the observing officer able to isolate the audio from a single cell, as well as whether it might assist to give observing officers a means to communicate with prisoners was explored to some degree at the Inquiry. There was no conclusive evidence as to whether the introduction of such a system of working might realistically prevent deaths in other circumstances. Some witnesses saw the benefits of such a proposal, but there

were also concerns about whether, without proper research, the introduction of such a system of working might distract officers from their main role of observations. As matters stand the Constant Observations Monitoring Group of Police Scotland are actively considering audio capability, including the isolation of cell audio, within observations rooms. Given the equivocal nature of the evidence I heard in relation to this specific issue, and the active work that is being carried out by Police Scotland in relation to the technology in its estate, I make no recommendations in relation to it.

[82] At the time of each of the deaths the ratio of observing officers to prisoners during constant observations appears to have been 1:4. However, I was not referred to any formal guidance in that regard upon which custody officers could rely. Instead, it appears to have been a legacy of the practice undertaken by the former Strathclyde Police. PC Whyte gave evidence that this could be too high in some circumstances. PI Gunn and PS McKenzie suggested that this was a matter which ought to be reviewed. I was not referred to any evidence to suggest that the position has changed since the deaths. From the evidence presented it remains the case that Police Scotland have no guidance or written policy addressing the appropriate ratio. There was evidence that some research had been carried out by Police Scotland as to safe observation ratios, however no definitive conclusion was reached. In their submissions, Police Scotland raised concerns about resourcing a reduced ratio due to "unprecedented" pressures on local police resourcing. The evidence presented does not lead to a conclusion as to what the appropriate resourcing level should be. Nevertheless, the absence of any guidance at all leaves a gap in Police Scotland's system

of working which might risk an officer being asked to monitor too many prisoners. Inspector Gunn noted that this issue ought to be reviewed to ensure any ratio used in practice was fit for purpose. Given the vulnerabilities of the prisoners being monitored, I consider that this gap carries an inherent risk to prisoner safety. I recommend that Police Scotland give urgent consideration to introducing formal written guidance to officers as regards the maximum ratio of observing officers to prisoners for constant observations as part of their system of working.

[83] As highlighted above, the system used by Police Scotland to provide breaks to officers conducting constant observations was unclear. The SOP in place at the time of both deaths stated that "consideration must be given to relieving the officer undertaking the observations on a regular basis". Further "Constant Prisoner Observations Operational Guidance" in place at the time of Mr Berry's death provided that observing officers should be relieved "on a regular basis" and that custody and local police supervisors should "work closely together" to ensure such breaks take place. At the time of the deaths the evidence suggests that the provision of breaks was irregular, and that officers could be on duty for a number of hours without one. There was no set maximum period of time before which observing officers were required to take a break. The provision of a break obviously heightens the ability of officers to focus and there was evidence to that effect from PC Whyte. I consider that the imprecise nature of the guidance and the regime for providing breaks was a factor in PCSO McCann and PC Whyte conducting observations for a prolonged period of time with no break. Another factor was the fact that the onus for ensuring a break to some

degree lay with the officers themselves: both knew that they could ask for a break, but neither asked.

[84] The SOP has now been updated and clarifies that it is for the custody supervisor to ensure that the observing officer receives "appropriate" welfare checks and breaks. The welfare checks are to take place whenever visits are made to the prisoner and recorded on the NCS. This provides some more formality and clarity to the regime for breaks. However, again the guidance lacks precision as to what an "appropriate" break might be. This absence of detail may lead to practice varying between police offices and, in practice, the regime for breaks essentially being unwritten in terms of the appropriate time frame. Moreover, it again places a degree of onus on the observing officer to request a break rather than a break being mandated to ensure the observing officer can focus suitably. As indicated above, at para [77], there did at one stage appear to be written guidance as to the appropriate time-frame for breaks, although this may have been informal. The absence of any formal regime of breaks for officers conducting constant observations leaves a risk of such officers being unable to perform their duties properly. Ensuring such officers are subject to a regime of appropriate breaks might therefore realistically prevent deaths of prisoners. I recommend that Police Scotland give urgent consideration to introducing a formal policy, set out in the SOP, as regards the period following which a break should be provided for officers conducting constant observations, and to such breaks being the subject of a system of recording.

[85] At the time of both deaths there was no training course designed specifically for officers undertaking constant observations. That remains the case. PCSO McCann and

PC Whyte gave evidence that they knew what kind of issues which they ought to be looking for, such as seizures, self-harm, signs of distress or any similar matters. I take into account the fact that training is provided to custody officers on the welfare of prisoners and first aid, which covers issues which might arise during constant observations, such as seizures. In addition there is and was guidance in the SOP, its Appendix I, and the additional operational guidance issued, all of which have been referred to above.

[86] I take account of the submissions of the Chief Constable that, in this context, where guidance is issued and officers have indicated an understanding of their duties, and where it has been established that a system of appropriate briefings for prisoners is being observed, that it is unclear what more is to be gained from introducing a formal training course. However, it is of note that during their evidence the witnesses spoke to training for constant observations being provided "on the job" with colleagues informing them how to perform their duties. The inference which I draw from this evidence is that officers seek guidance informally on the role, but that, in the absence of any training, the nature of the guidance provided by colleagues is not formalised, monitored or recorded. It is of course natural for any individual new to a particular role to learn "on the job" to some extent with the help of more experienced colleagues. However, it is of importance, in my view, when dealing with prisoners whose vulnerabilities require constant observations, that those conducting such observations can immediately be identified as appropriately trained.

[87] It has to be noted that the training which is provided to custody staff in relation to seizures does not form part of a course specifically linked with constant observations. In evidence the witnesses had difficulty recalling the specific training course in which it was covered, referring more to what they understood it would involve and guidance from colleagues. The training courses which are provided on prisoner welfare cover a wide-range of issues. It is not immediately apparent which parts of the training relate to observation duties as opposed to other general custody duties. In cross-examination of PCSO McCann by Mr Clarke an issue arose as to whether he had in fact completed the appropriate training courses allowing him to work within the custody suite on the night of Mr Berry's death. When presented with his training record PCSO McCann was not certain that he had. There was also confusion in relation to the status of aspects of the guidance. In the Chief Constable's closing submissions reliance was placed on the aide-memoire in Appendix I to the SOP. However, in the latest version of the SOP that Appendix has been removed.

[88] I consider that the *ad hoc* or informal nature of some of the constant observation training, and the disparate nature of the relevant guidance and resources could be improved upon. It was of note that both Inspector Gunn and Inspector Nicolson noted the difficulties which could arise with updates to written guidance. Inspector Gunn noted the frequency with which the SOP can change, and suggested that Police Scotland might want to consider alternative methods of keeping officers updated on the processes and procedures expected of them. Inspector Nicolson noted issues with self-briefings (ie the process by which staff update their knowledge individually

through, for example, staff memos) such as a lack of monitoring or compliance. Both were clear that it was incumbent upon Police Scotland to ensure that their staff are competent and capable of performing their duties. As Inspector Gunn pointed out, officers on constant observations perform a crucial role in ensuring prisoners' wellbeing is maintained and that risks in their detention are mitigated. Standing the particular vulnerabilities of those being monitored under constant observations, I recommend that a module of focussed appropriate training on this duty, formally outlining what it entails, the risks involved, what signs to look for, and what action to take might be introduced, and that an accessible record be kept to ensure that those placed on constant observation duties have completed it.

Referral to Health Care Professional (HCP)

[89] Once the vulnerability questions have been completed, a decision can be made by a custody supervisor to refer a prisoner to an HCP from the police custody healthcare team. The main base for that team is in Govan, although staff work on a peripatetic basis and may not always be there. The base comprises nurse practitioners, but there are also forensic practitioners who may be contacted by the nursing team. Referrals are normally made by a phone call, then allocated by the shift co-ordinator, depending on the information provided, the clinical need and workload across the custody estate. The case is then allocated to the most appropriate HCP based on their level of knowledge, skill and experience. If the referral is urgent, then the case might be

allocated to the nearest HCP, or the custody staff might be instructed by the healthcare hub staff to take the prisoner to the emergency department.

[90] Where a referral relates to continuation of medication, staff at the healthcare hub would seek to confirm that the medication is in date and being collected by the prisoner. They would seek to continue medication where it is possible and safe to do so, either from their own stock or from a pharmacy or hospital ward. Staff have access to a number of healthcare systems. The ADASTRA system is used by them to enter clinical assessments and further reviews of individuals referred by custody staff. The Egton Medical Information System (EMIS) is accessible in relation to the Greater Glasgow and Clyde area, and is the system used by Mental Health and Addictions services. The Emergency Care Summary (ECS) allows the prescription of medication to an individual to be confirmed. The Clinical Portal allows staff to access the medical history or active care of individuals on other clinical systems with the consent of the individual concerned. HCPs do not have access to Prison Health Care records.

[91] At the time of both Mr Gallacher's and Mr Berry's deaths the respective SOPs in place made clear that medical provision for prisoners was the responsibility of NHS Scotland. They further stated that it was the responsibility of the custody supervisor to make contact with the HCP if medical advice or assistance was required for a prisoner. They made clear the circumstances which would require a referral to the HCP as follows:

> "18.1.2 Any reference to an HCP includes Doctors, Nurses and Paramedics. A prisoner should be seen by an HCP if there is reason to believe that they;

- Are suffering from any illness or injury including alcohol and drug withdrawal if applicable.
- Have taken drugs, including New Psychoactive Substances (NPS – legal highs)
- Have consumed any other substance which might conceivably cause harm.
- Have indulged in solvent abuse.
- Are a pregnant female.
- Appear to be suffering from a mental illness
- Whose condition is such to suggest that he/she requires medical assistance."

They made clear the custody supervisor was to discuss the case with the HCP to determine whether a visit was required, or whether the prisoner was to be taken to hospital. They stated that particular care was required for prisoners who were drunk, under the influence of drugs or who had a head injury in combination with alcohol or drugs. Where a prisoner appeared drunk and drowsy, those prisoners were to be placed in the recovery position with medical assistance to be summoned immediately.

[92] The SOPs in place also offered guidance in relation to prisoners who had been hospitalised from a custody centre and then returned from hospital. They provided that escorting officers should note the written care instructions from hospital staff, where provided, in a form (Form 051-005), or in their notebooks. Escorting officers were to inform the custody supervisor of all relevant information which might impact on the care and welfare of the prisoner, and provide all relevant medical notes or forms. The custody supervisor was to convey this to the HCP. The respective SOPs also made clear that where a prisoner was certified in hospital as "fit to be released", the custody supervisor was still to assess, in consultation with the HCP if necessary, the prisoner's fitness to be held in custody. It was stated that the custody supervisor "must satisfy

themselves that a prisoner is fit to be detained in custody and should be prepared to challenge healthcare advice to ensure robust decision making".

[93] In relation to Mr Gallacher, the evidence was that, at the charge bar, he was intoxicated, although he could hold a conversations and appeared aware of his surroundings. He was initially aggressive with officers, but eventually calmly answered their questions. He gave information that he could take as many as 15 to 20 Xanax a day, that he was trying to cut back, and that he had taken one that day around 12 hours previously. He also indicated that withdrawal symptoms could occur after around 6 hours, that he had suffered seizures following withdrawals in the past, and that he last suffered a seizure 6 weeks prior to his arrest. Sergeant McKenzie provided his reasoning for his decision not to refer to an HCP: Mr Gallacher's seizure had taken place some time ago; he appeared well and cognisant of his surroundings; and he was not complaining of withdrawal symptoms. Sergeant McKenzie also believed that the policy of the Health Care Hub was that no HCP would attend prior to Mr Gallacher's release. He cited a protocol which meant that nobody would be sent to provide further medication until 6 hours had elapsed. Inspector Gunn indicated that a referral of every prisoner who had taken drugs would be highly impractical in practice and that a difference fell to be drawn between someone who had suffered withdrawal symptoms in the past and someone who was actually suffering withdrawal symptoms. He indicated that the question of referral had to be based on the officer's observations in the particular case, that in his experience an HCP would not have attended to Mr Gallacher

and, if anything, he might have categorised Mr Gallacher as a lower risk during processing.

[94] I have taken the evidence of DI Gunn and Sergeant McKenzie into account. Nevertheless, it is my finding that the terms of the SOP in place at the time of Mr Gallacher's death was not followed in relation to a referral to an HCP. One of the factors set out as justifying a referral, the ingestion of a drug, was clearly present. When that was combined with the information in relation to Mr Gallacher's normal drug intake, the timing of the ingestion, when withdrawal symptoms usually began and his history of seizures, the terms of the SOP suggested that the HCP ought to have been notified. I find support for that finding in the evidence of Sharon Campbell, a Senior Charge Nurse from Greater Glasgow Health Board, who stated that, if provided with Mr Gallacher's background information, she would have probably recommended that he be placed on constant observations and informed staff that she would visit him. This would depend on the urgency of other referrals and any further information about the prisoner. She denied that there was any protocol involving a period of 6 hours in relation to the provision of medication, but indicated the decision as to whether administer further medication depended on a number of factors, and that diazepam or sedative drugs were unlikely to be provided. I consider that these are clinical decisions which, in terms of the SOP, ought to have been referred to the HCP. That was a reasonable precaution which ought to have been taken. However for the reasons set out in relation to the medical evidence below, I do not consider that, had it been taken, it might realistically have resulted in Mr Gallacher's death being avoided.

[95] In respect of Mr Berry, I also find that the terms of the SOP in place in relation to a referral to HCP was not followed. Even absent the knowledge of Mr Berry's prescriptions, such a referral ought to have been made. That was ultimately the position of Inspector Nicolson in evidence. Her report was more unambiguous in this regard, stating that Mr Berry ought to have been referred to the HCP or returned to hospital as he could not walk or talk. The CCTV footage showed Mr Berry to be intoxicated, to be slurring his words and unsteady on his feet with his head down and requiring support from officers. He was also aggressive and abusive towards custody staff. The evidence of some of the police officers to the Inquiry was that Mr Berry was making a decision not to engage at the charge bar and was pulling himself to the ground. Evidence was given that his demeanour in the holding cell before the charge bar suggested that he was able to support himself and talk. At one point in her evidence Inspector Nicolson appeared to agree with this. Having viewed the evidence, I am not sure of that assessment. CCTV footage of Mr Berry being taken from the police car into the police station shows him to be unsteady on his feet, at one point stumbling and being supported by police officers to prevent him falling. Again, this was ultimately accepted by Inspector Nicolson, albeit in cross-examination.

[96] The SOP was clear that care had to be taken with prisoners who were intoxicated. In that regard, the NCS note created by Sergeant McGhee noted Mr Berry as being "heavily intoxicated" and "unable" to complete the care plan. In addition Mr Berry was repeatedly shouting for help. I take account of the evidence from Inspector Nicolson and others that an assessment has to be made in relation to such

outbursts, and that prisoners may shout for help even when they are suffering no real pain or discomfort. However, Mr Berry also indicated at the charge bar that he took seizures. When that is considered, along with the fact that Mr Berry had not completed the vulnerability questions at that stage, and was evidently intoxicated, the decision ought to have been made to refer him to the HCP. That becomes even more apparent given that a lamotrigine prescription had been found on his person and ought to have been highlighted by those processing him.

[97] There are a number of factors at play which may have prevented the referral of Mr Berry being made. Most importantly, it is not clear that Sergeant McGhee was ever told that Mr Berry suffered from seizures or had been found with prescriptions. This information, along with Mr Berry's presentation at the charge bar, ought to have been recorded in the notes section of the NCS and brought to his attention. The evidence also suggested that the fact Mr Berry had been released from hospital may also have influenced officers' approach. Sergeant McGhee's note on the NCS records that Dr Stevenson deemed Mr Berry "fit to be detained". The fact that he had recently been at hospital was a factor referred to by a number of witnesses who gave evidence. Moreover, some of them were aware that Dr Stevenson had acted as a Forensic Practitioner for the police and was therefore aware of their detention procedures. However, as highlighted by Inspector Nicolson, while the question of fitness to be released from hospital is a matter for staff at the hospital, the question of fitness to be detained is separate and must be considered at the stage of detention. As highlighted above, this was made clear in the SOP in place at the time.

[98] Sergeant McGhee considered that, had he been aware of Mr Berry's full background circumstances, he would have made an earlier referral to the HCP. However, it is of note that he did not believe that, had he done so, an HCP would have seen Mr Berry immediately "if at all". His explanation, again, relates to his perception that there was a policy in place from the healthcare hub whereby prisoners would not be seen until a period of 6 hours had elapsed, in order to allow any drugs in a prisoner's system to wear off and to avoid the risk of an overdose. Again, such evidence as I was presented with by NHS staff from the healthcare hub suggests that there is no such policy in place. In all the circumstances, I find that an earlier referral of Mr Berry to an HCP was a precaution which could reasonably have been taken. However, again, for the reasons set out in relation to the medical evidence below, I do not consider that, had it been taken, it might realistically have resulted in Mr Berry's death being avoided.

[99] Police Scotland's SOP in relation to the care and welfare of prisoners has now been updated. Version 19 is the current version. It makes clear at a number of points the duties upon arresting officers and custody staff in relation to the health of prisoners. It states that a custody supervisor may decide that clinical attention by custody healthcare staff is needed before a decision on fitness to be detained is made, irrespective of whether the person has received medical attention elsewhere. It now states that the written care instructions from hospital staff, where provided, be noted in Form 051-005, police notebooks, or mobile working device regardless of whether a person has been taken to hospital as an arrested person or arrested at the point of discharge from a hospital. This information must be provided to the custody

supervisor, who will in turn convey this to the HCP. It states that while hospital staff may certify an individual as "fit to be discharged", they will not certify that person as "fit to be detained" and must "never be asked" to make a judgement on this. It reiterates that this is a matter for the custody supervisor, in consultation with the custody HCP if necessary, and that the supervisor must be prepared to challenge healthcare advice. This provides clarity as to the distinction between fitness to be discharged and fitness to be detained.

[100] The section in the SOP in relation to HCP referrals has also been amended, and now reads as follows:

> "A person in custody must be referred to an HCP if there is any reason to believe that they;
>
> - Are suffering from any illness or injury (depending on severity) including alcohol and drug withdrawal if applicable.
> - Have consumed any other substance which might conceivably cause harm.
> - Have indulged in solvent abuse.
> - Are pregnant.
> - Appear to be suffering from a mental illness.
>
> The custody supervisor is to discuss the case with the HCP to determine whether a visit is required or not, or to arrange for the removal of the individual to hospital, even though the person may have not complained of their condition nor requested the services of an HCP.
>
> Note - Where an individual has taken drugs and is symptomatic, or if there is any delay in an HCP being able to assess the person in custody, consideration should be given to taking them straight to hospital.
>
> Particular care is to be taken in relation to persons who are;
>
> - Drunk.
> - Under the influence of drugs.
> - A combination of a head injury and alcohol / drugs.

> If a person appears to be drunk and drowsy to the point they cannot be easily roused, they are to be placed in the recovery position and medical assistance summoned immediately."

[101] A number of witnesses were asked about the advantages of this guidance as now reframed. In particular, there was evidence that the removal of the bullet point requiring a referral where drugs had been taken was more practical. It allowed an assessment to be made by custody staff on such matters and a judgment call to be made based on their experience. It avoided the difficulty of an impractical guideline being in place which would have suggested that an unreasonably high proportion of those detained be referred to the HCP.

[102] The effective care of prisoners must clearly prevent staff at the healthcare hub being overburdened unnecessarily. However, the focus of any changes ought not to be aimed more at easing pressure on custody staff rather than the care of prisoners *per se*. Of equal, if not greater, importance is that those arrested are seen by HCP as and when required. There were submissions from some of the parties to the Inquiry suggesting that the English model be followed, whereby medical staff are present at police stations to make decisions on fitness to be detained. However, I was not presented with any real evidence as to the procedures followed in England and such fundamental changes are beyond the scope of this Inquiry. Nevertheless, in order to ensure referrals to an HCP are made at the appropriate time custody staff require proper guidance and support. I consider that the SOP in relation to referrals still lacks clarity in a number of key respects.

[103] The deletion of the bullet point referring to drugs creates a non-sequitur in the guidance. The bullet point which immediately followed it remains in place and refers to the consumption of "any other substance". There is now no prior bullet point referring to the consumption of any substance, albeit the prior paragraph does refer to alcohol and drug withdrawal. More generally, the reference to any substance which may cause harm is vague. On one view it could in fact include drugs or alcohol, but from the evidence presented that does not appear to be the intention or the interpretation adopted in practice. Instead, it appears to be aimed at the ingestion of toxic substances such as bleach or other things which one would not normally expect to find in the human body. This is further complicated by an earlier section in the SOR headed "Persons Suspected of Swallowing Drugs" which states "if it is known or suspected that a person has swallowed or concealed drugs the person must be taken to hospital". While this seems to be aimed at those who have swallowed large packages of drugs, it is drafted in broader terms than that. On one interpretation it would apply to any person who had ingested any drug.

[104] More fundamentally, while a large number of arrested persons may have ingested drugs or alcohol that, of itself, does not merit that criterion being deleted entirely as a potential issue requiring referral. Indeed, again earlier in the SOP, in the section on "Intoxication", it is made clear that a person who is unable to walk, talk or maintain a coherent conversation as a result of intoxication should be subject to "prompt medical assessment/conveyance to hospital". In the paragraphs immediately following the bullet points setting out the circumstances in which a referral "must" be

made to the HCP, it is stated that where someone has taken drugs "and is symptomatic" consideration should be given to taking them straight to hospital rather than waiting for the HCP to attend. Reference is also made to "particular care" being required for persons who are drunk or under the influence of drugs. These pieces of guidance beg the question as to why the ingestion of drink or drugs has been removed entirely from the bullet points requiring a referral.

[105] Looked at from another perspective, it is doubtful that the guidance intends that the ingestion of any amount of potentially harmful substance, or the abuse of solvents even to a very small extent much earlier in the day warrants a referral to the HCP on every occasion. On a similar note, the interpretation by custody staff who gave evidence sought to draw a line between those who had suffered drug and alcohol withdrawal symptoms and those who were suffering such symptoms at the time. On their interpretation, it was only the latter category who required to be referred. However, it would perhaps be concerning if, for example, someone who had suffered such symptoms only a matter of days, or even hours before, and had since ingested drugs and alcohol was not considered suitable for referral. Once more, to advise custody staff that a referral must be made in relation to any illness or injury "depending on severity" but to fail to thereafter provide any specific indicators of severity leaves non-clinical staff looking for guidance in a difficult position. All of this leaves open the possibility of uncertainty in relation to the steps custody staff should take as regards referrals.

[106] I accept that the SOP guidance on the referral of prisoners to the HCP cannot be read in a vacuum. Custody supervisors will have experience of dealing with the welfare issues of prisoners which will help their decision-making process. The Chief Constable's submissions referred to training in module 5 of officers' induction training, which is delivered in person by an experienced HCP. This covers an outline by the HCP as to when they should be called upon for assistance or advice. There is also a document providing a "traffic light" approach to referrals outlining the criteria which would suggest an immediate phone call, those which might require a standard healthcare response, described as within 4 hours, and those which would merit a "routine" response. This is displayed in custody suites. However, where there is potential doubt or confusion about the circumstances in which a referral should be made, risks arise as to the welfare to those being accepted into custody. The evidence I heard suggests that there is in fact confusion about the circumstances in which a referral is appropriate, due to the apparently widely held belief among police staff that the HCP will not attend someone who has ingested drugs until a period of 6 hours has passed. The evidence provided by the witness Campbell from the NHS custody staff suggested that there was no such protocol.

[107] I consider that greater clarity should be provided in the guidance in the SOP as to the criteria which should be considered in determining whether a referral should be made. There were some implicit criticisms of the guidance issued prior to version 19 as it was suggested that NHS staff were not consulted. I recommend that the guidance on when a referral to HCP should be made be reviewed in collaboration with the NHS

healthcare hub staff. The form of the guidance is best determined by Police Scotland and the NHS staff. However, it seems to me that more detail is required in relation to the criteria to be considered in a referral and that those highlighted in the traffic light poster might provide a helpful starting point. It would also be of assistance if some indication were to be given as to expected response times where possible. At the very least, if there is no policy of a minimum wait of 6 hours before a prisoner is seen, that should be made clear. I consider that this change might realistically prevent deaths of other prisoners in custody by ensuring that timely and appropriate HCP referrals are made.

Medical evidence

[108] In the foregoing paragraphs I have identified a number of precautions which might reasonably have been taken prior to the deaths of both Mr Berry and Mr Gallacher. I have, however, come to the conclusion that there was insufficient evidence before me to suggest that, had these precautions been taken, any one of them might realistically have resulted in either death being avoided. Similarly, I have come to the conclusion that there is insufficient evidence to suggest that any of the defects identified in the systems of working at the time of each death contributed to those deaths. I have to approach the statutory test as to whether a precaution might realistically prevented either death by considering if there is a real or likely possibility, rather than a remote chance, that it might have so done. Whether a defect in any system of work contributed to either death must similarly be approached with a view to what

has been established on the evidence as regards what effect such failings might have had in relation to the deaths. In this regard the medical evidence presented has to be considered carefully.

[109] In relation to the death of Mr Berry a number of expert reports or affidavits were obtained. Dr Kieren Allinson, consultant neuropathologist, concluded that his death was consistent with Sudden Unexpected Death in Epilepsy (SUDEP), due to a combination of epilepsy and alcohol withdrawal in the context of chronic alcohol abuse. He indicated that Mr Berry may have missed one or two doses of lamotrigine. This increased his risk of SUDEP. However, it was not possible to quantify that increased risk. If Mr Berry had been taken to hospital, resuscitative measures might have been taken, including anti-seizure medication, which might have reduced his chances of dying. However, Dr Allinson's opinion was that it was not possible to state on the balance of probabilities whether Mr Berry's death would have been avoided had these steps been taken. Doctor Julia Bell, a forensic pathologist reached a similar view, albeit she felt a more general cause of death encompassing all the relevant factors was more appropriate than SUDEP. She felt that, as Mr Berry had been assessed at hospital only a few hours earlier, there was no obvious reason, such as the symptoms he was exhibiting, for him to be referred back to hospital. If he had not missed a dose of medication, or the seizure had occurred in hospital, this "may" have reduced the risk of a seizure related cardiac arrest, but it was not possible to be certain that the outcome would not have been the same. A report was obtained from Dr Rudy Crawford, consultant in Accident and Emergency Medicine, which suggested that had Mr Berry's

seizure been witnessed and CPR been commenced within minimum delay, his chances of survival would have been significantly greater. The weight which I placed on this assertion in the report was limited. Dr Crawford also stated in the report that it could not be said that Mr Berry would have survived the event in such circumstances, and that his chances of survival would still have been low, undermining his earlier assertion.

[110] In relation to the death of Mr Gallacher, Dr Gemma Kemp, Forensic Pathologist, concluded that even had he been found unresponsive at an earlier stage it was "unlikely" that his life would have been saved. She made clear that early medical attention would increase the chances of survival, but that with sedative drugs such as those taken by Mr Gallacher there was no antidote to quickly reverse their effects. Dr Crawford also provided an opinion stating that the outcome for Mr Gallacher "may" have been "different" had a medical referral been made. That was not further expanded upon. Again, the weight which I was able to place on this assertion by Dr Crawford was limited.

[111] The evidence presented at the Inquiry has not satisfied me on the balance of probabilities that any of the precautions identified might realistically have resulted in either death being avoided, or that any defect in the system of working directly contributed to either death. The weight of medical evidence is that earlier interventions might have increased the chances of survival in respect of both Mr Berry and Mr Gallacher to a limited degree, but that there was nothing to suggest that their survival was a real or likely possibility. In each case the chances of survival, even with

such intervention, remained low. To conclude that had certain steps been taken at an earlier period of time the deaths might have been avoided would involve, in my view, speculation about a remote outcome for which insufficient medical evidence was presented. The defects in the systems of working may have contributed to the medical attention that both Mr Berry and Mr Gallacher received being provided later than it might otherwise have been, but there is no evidence before me to suggest on the balance of probabilities that this contributed to their deaths. Even with earlier intervention, their chances of survival remained low.

Other issues arising

[112] During the course of the Inquiry a number of other issues were touched upon in evidence. There was evidence that some former Strathclyde Police staff used legacy codes to describe prisoners for system entries. However, such evidence as there was suggested this was restricted to a limited number of staff. On the balance of probabilities it does not appear to be a widespread systemic issue. There was evidence about the process adopted, in the past and currently, in relation to briefings provided to custody staff for prisoners within the custody suite. However, I did not consider that the system of briefings raised any systemic issue in this case. There was evidence about prior guidance to custody officers suggesting that they might on occasion have to examine prisoners for pupil dilation and other matters. This guidance has now been removed. I did not consider that this guidance was material to the issues which arose in this Inquiry. There was also evidence which suggested that the extent to which

healthcare professionals have access to a prisoner's former prison records might be limited. It is arguable that it might be best practice for a doctor to have access to prisoners' full medical records. However, this might also raise issues about confidentiality, privacy and ethical medical considerations. I did not hear sufficient evidence in relation to this matter to allow me to make any formal recommendation in relation to such fundamental matters.

Conclusion

[113] This Inquiry has focussed upon the deaths of Mr Gallacher and Mr Berry while they were in lawful police custody. As such I have set out the background circumstances to each of their arrests. However, I am aware that the experiences which may have led them to that point in their lives, their importance to those they have left behind, and the sadness which the latter feel could never by captured by any Determination I make. I do however wish to record the patience and dignity with which the families of both approached the Inquiry process. I also wish to thank them for their assistance in that process, in matters such as the agreement of evidence, and in the case of Mr Clarke, a lay representative, the care, attention and skill with which he approached the evidence and the questioning of witnesses. Finally, I join with parties in expressing my sincere condolences to each family for their respective losses.