

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

B1323/09

2011 FAI 3

***INQUIRY HELD UNDER
THE FATAL ACCIDENTS
AND
SUDDEN DEATHS
INQUIRY (SCOTLAND)
ACT 1976,
SECTION 1(1)(a)(ii)***

DETERMINATION

by

IAN HARPER LAWSON MILLER, Esquire,
Advocate, Sheriff of the Sheriffdom of Glasgow
and Strathkelvin

following an Inquiry held at Glasgow on 2nd, 3rd,
and 4th November all days of 2009, and 21st and
22nd January, 4th March, 28th May, 13th July, 30th
and 31st August, 7th September and 26th
November all days of 2010

into the death of

PAUL RAINEY

GLASGOW, DECEMBER 2010.

The sheriff, having resumed consideration of the evidence, productions, joint minute of agreement and the submissions thereon,

FINDS AND DETERMINES:

- (1) In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that Paul Rainey, who was born on 23rd March 1967, and who resided latterly at Flat 80, 40 Kennishead Avenue, Glasgow G46 8RF died on 12th April 2008 at 15.41 hours at the Victoria Infirmary, Glasgow.
- (2) In terms of section 6(1)(b) of the said Act, that the cause of his death is undetermined;
- (3) In terms of section 6(1)(c) of the said Act, that there were no reasonable precautions whereby his death might have been avoided;
- (4) In terms of section 6(1)(d) of the said Act, that there were no defects in any system of working which contributed to his death; and
- (5) In terms of section 6(1)(e) of the said Act, that there were and are no other facts which are relevant to the circumstances of his death.

NOTE

[1] This Fatal Accident Inquiry (“the Inquiry”) has been convened to inquire into the circumstances of the death of Paul Rainey (“Mr Rainey”) which occurred on 12 April 2008. He was then 41 years of age, having been born on 23 March 1967. He resided latterly at Flat 80, 40 Kennishead Avenue, Glasgow G46 8RF.

[2] The Crown applied to the Court for the holding of the Inquiry because at the time of his death Mr Rainey was in police custody. It has therefore proceeded under section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the Act”).

The background to the Inquiry

[3] The Inquiry concerned itself with the events in the life of Mr Rainey from the point in time when he was arrested on 11 April 2008 until he was pronounced dead on 12 April 2008, a period of some twenty seven hours in duration.

[4] For all but a few moments at its commencement and when on the way to and at the Victoria Infirmary, Glasgow he spent his time in police custody within Cathcart Police Office, Glasgow. As such he was in the care of a large number of Strathclyde Police officers and support staff.

[5] The arresting officers were Police Constables Stuart Johnston and Alan McDougall. The succession of custody sergeants on duty was: Sergeant David Bennie who was on duty on 11 April from 12.45 hours until 20.45 hours; then Sergeant Stewart Dunsmuir from 20.45 hours until 05.45 hours on 12 April; then Sergeant James Jamieson from 05.45 hours until 12.45 hours; and then back to Sergeant Bennie from 12.45 hours until 20.45 hours. The succession of station inspectors was: Inspector Graham Wilson who was on duty on 11 April from 12.45 hours until 20.45 hours; another Inspector from 20.45 hours until 05.45 hours; then Inspector Andrew Calderwood from 05.45 hours until 12.45 hours; and then back to Inspector Wilson from 12.45 hours until 20.45 hours.

[6] There were other more senior police officers that became involved directly and to some extent in the care of Mr Rainey. Chief Inspector William Carle was the deputy sub divisional officer for G division which serves the south side of the city of Glasgow. On both 11 and 12 April he was the senior officer covering G Division of the City of Glasgow and was on duty from 08.00 hours until 16.00 hours on both days. Superintendent Kirk Kinnell was then a Chief Inspector who was the on call senior officer on duty on 12 April from 08.30 hours.

[7] There were in addition a number of police custody and support officers (“PCSOs”). Louise McDonald, Lynn Docherty and Alan Donegan were all on duty from 13.15 hours until 21.15 hours on both 11 and 12 April, Lisa Lindsay was on duty from 21.15 hours on 11 April until 06.15 hours on 12 April and Samuel Hardie was on duty on 12 April from 06.15 hours until 13.15 hours.

[8] Mr Rainey was also seen by two police casualty surgeons, Doctor Mark Reid and Doctor Philip McNaught. Doctor Reid was on duty on 11 April. He was asked to see Mr Rainey and he examined him at 17.17 hours on 11 April. Doctor McNaught was on duty on 12 April, was asked to see him and did so at 14.10 hours.

[9] After Mr Rainey was found in distress in his cell he was attended to by Doctor McNaught and Shaun McGranahan, a paramedic.

[10] On 17 April, Dr Linda Iles, a forensic pathologist at the University of Glasgow conducted a post mortem on the body of Mr Rainey on the instructions of the Procurator fiscal, Glasgow.

[11] After post mortem she gave his cause of death in her registration of his death in the district of Glasgow on 18 April as “Undetermined” with the qualification that this cause was given pending investigations (Crown Production number 1). She subsequently submitted her post mortem report dated 27 May (Crown Production number 2) which repeated that the cause of death was undetermined. She gave it as her conclusion that whilst no definite cause of death had been identified, there was no post mortem evidence of violence or injury contributing to his death, and given his history of alcohol abuse and seizures on abstinence, the circumstances surrounding his death and toxicological findings, the possibility that he died as a result of complications of alcohol withdrawal had to be considered.

The Inquiry

The parties to the Inquiry

[12] The interested parties represented at the Inquiry in addition to the Crown were the family of Mr Rainey, the Medical and Dental Defence Union on behalf of Doctor Reid and Doctor McNaught and the Chief Constable of Strathclyde Police on behalf of his officers.

The witnesses

[13] In the course of the Inquiry the Crown led the evidence of 18 witnesses. They were, in the order of giving evidence, Helen Rainey, known as Elaine Rainey, a sister of Mr Rainey, PCSO Alan Donegan, PCSO Louise McDonald, PC Stuart Johnston, PCSO Lynn Docherty, PCSO Lisa Lindsay, PCSO Samuel Hardie, Police Sgt David Bennie, Chief Inspector William Carle, PC James Jamieson, Superintendent Kirk Kinnell, Police Inspector

Graeme Wilson, Police Inspector Andrew Calderwood. Shaun McGrahan, P Sgt Stewart Dunsmuir, Doctor Mark Reid, Doctor Philip McNaught and Doctor Marjorie Black a consultant forensic pathologist at Glasgow University who gave evidence on the post mortem findings and report because Dr Iles was no longer available to give that evidence. The family led the evidence of Doctor Katherine Morrison, an experienced police casualty surgeon. No further witnesses were called.

The Joint Minute of Agreement

[14] As witness to fact succeeded witness to fact it became increasingly evident that there was complete agreement on all the material facts relating to the physical condition of Mr Rainey at the material time, his long and consistent history of alcohol and drug abuse, and the involvement of each police officer, police support officer and casualty surgeon in his care whilst he was in police custody. The same applied to the evidence of Doctor Black which supported entirely the conduct of the post mortem, the findings and the conclusions drawn from them. In light of all that, the parties represented at the Inquiry entered into a Joint Minute of Agreement. It consisted of 211 paragraphs and agreed the evidence of the witnesses to fact on all facts that were material to the Inquiry. It is a highly detailed and comprehensive document, obviously the fruit of a great deal of work. I wish to commend the parties for proceeding in this way and in particular to thank those who devoted what must have been a substantial amount of time and thought to its drafting. Rather than incorporate its terms in this Note at this point I have repeated them as Appendix One to it.

The proposed issues

[15] In addition and consistent with the welcome spirit of co-operation shown by the creation of the Joint Minute, the Crown at the same time intimated a note of the issues that they wished to explore with any skilled witness called by any of the other parties. The pivotal one asked whether a finding could be made regarding the cause of Mr Rainey's death, other than that it was undetermined, and the others raised questions relating to the adequacy of procedures, the appropriateness of certain actions and responses and whether the death could have been avoided by a change in recording information or procedures for risk assessment or if certain resuscitation equipment had been available. All of them really depended upon the Inquiry making a finding of death that was other than undetermined. None of the other represented parties intimated a wish to add to the number of the issues.

The effect of the evidence of Doctor Morrison

[16] In the event the only skilled witness that was called and gave evidence was Dr Morrison. It was during her cross examination by the procurator fiscal depute that she gave evidence about the cause of Mr Rainey's death that meant that no further expert evidence would be led. Prior to her evidence much time had been taken up with questioning the witnesses to fact, including the casualty surgeons and also Doctor Black, predicated on the assumption that Mr Rainey had suffered a seizure in his cell related to withdrawing from dependency on alcohol. When Dr Morrison, under reference to paragraph 177 of the Joint Minute, was told in the course of her cross-examination what she had not known previously that it was Mr Rainey who had activated the buzzer in his cell at approximately 1450 hours on 12th April, she opined that that fact excluded the possibility that he was suffering from a seizure then or between then and the time when he was observed lying still on the floor of his cell, which she had understood was between thirty seconds and one minute. With only a momentary pause to collect her thoughts, she was happy to continue to give her evidence in light of that new understanding, and she included it in her comments and conclusions. At the end of her evidence her opinion on this critical issue remained unshaken.

[17] This revelation had been hinted at already in evidence given by Doctor McNaught and Doctor Black: by Doctor McNaught when he said that although there was a general assumption that Mr Rainey had suffered an alcohol withdrawal seizure in the cell, when he attended there on being summoned to help him, he saw no signs of such a seizure; and by Doctor Black when she had said that it was unlikely that Mr Rainey had suffered a seizure if the time between him activating the buzzer and the arrival at his cell of a custody officer had been, as the questioner put it, only a few seconds. Although she was not told the actual lapse of time, which was accepted as being thirty seconds in paragraph 179 of the Joint Minute, her opinion as an expert pathologist lent credence to the contemporaneous perception of Doctor McNaught.

[18] The effect of Doctor Morrison's evidence was immediate and significant. After an adjournment of several days for the parties to consider the implications of it all represented parties confirmed that the cause of death given in the death certificate could no longer be challenged successfully, would have to remain as "undetermined", and as a consequence of that it was no longer possible to seek a determination under section 6(1)(c), (d) or (e) that was anything other than formal.

The consequential submissions

[19] In advance of the diet assigned for submissions all parties presented written submissions. Each was aware of the others and importantly the family of Mr Rainey were made aware of them all. This was a most helpful practice which I commend. In the submissions all parties concurred in accepting that the determination under section 6(1)(b) had to be as given in the death certificate and the post mortem report, that the cause of death was undetermined, and consequently each requested formal determinations under section 6(1)(c), (d) and (e). It was under section 6(1)(a) that there arose a difference of opinion. All save the family wanted the determination to repeat the terms of the post mortem report and the death certificate which were that Mr Rainey died on 12 April 2008 at 15.41 hours in the Victoria Infirmary, Glasgow. By contrast the family wanted it to say that he had died sometime after 14.56 hours and prior to 15.19 hours on 12 April 2008 within Cathcart Police Station.

[20] As a consequence of the prior circulation of the written submissions I decided that there was no need for the parties' procurators to read out the terms of their own submissions and instead each procurator could confine herself or himself to adding to the submissions or commenting on the submissions of the other parties. Copies of all submissions were lodged in process: because of that there is no need for me to repeat or even précis them in this Note.

[21] In furtherance of that the procurator fiscal depute submitted that she had nothing to add to the Crown's submissions and did not wish to make any comment on the other submissions. Mr. Thomson supported his request that under section 6(1)(a) the time and place of death be determined as sometime after 14.56 hours and prior to 15.19 hours on 12th April 2008 within Cathcart Police Station by reference to the reasons given in the submissions for the family, namely that it could be inferred from the facts numbered 190, 194, 197, 199-203 in the Joint Minute taken together with the evidence that paramedics were contacted at 14.56 hours and arrived at Mr Rainey's cell at 15.03 hours and Doctor Morrison's evidence that in her opinion Mr Rainey died whilst in Cathcart Police Station and then by invoking the concept of judicial knowledge of the proposition that "the longer a person's heart does not function, the more likely it is that imminent death will result". Beyond that he added nothing to the family's submissions and had no comment to make on the other submissions. Mrs Robertson said that she had nothing to add to her submissions

and as for any determination under section 6(1)(a) time of death in general was not an easy matter to assess, there had been no evidence of it before the Inquiry and the quality and strength of such evidence as there had been did not rebut the presumption that the time and place of death was as in the post mortem report and the death certificate. Beyond that she had nothing further to add. Mrs. Stannage said that she had nothing to add to her submissions and no comment on the other submissions.

My determination

[22] The duty on the sheriff presiding over a fatal accident inquiry is set out in section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the Act”). It is to hear all the evidence tendered and any subsequent submissions made on that evidence, and then make a determination setting out the circumstances of the death of Mr Rainey under reference to the five considerations set out in that section, in so far as they have been established to my satisfaction. Those five are: -

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death.

The scope of all fatal accident inquiries is determined, delineated and circumscribed by this subsection.

[23] The function of the sheriff at a fatal accident inquiry in making his determination does not include making any finding of fault or apportioning blame between any persons who might have contributed to the accident. The Act that governs inquiries does not empower the sheriff to do that. It is a fact finding inquiry not a fault finding inquiry. It is inquisitorial in form rather than adversarial. The standard of proof of the circumstances of the death is on the balance of probabilities. The onus of proof rests on the Crown because, by virtue of section 1 of the Act, the duty of investigating those circumstances lies on the Crown. The word “accident” is not defined in the Act. In its common usage, an ‘accident’ is an

unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.

[24] On the question of what facts I use in making my determination I am satisfied that I can and should use the contents of the Joint Minute as the sole source and measure of those facts. I do not need to go beyond its contents. That is a mark of the quality and comprehensiveness of the Minute. That means that I do not need to make any assessment of the reliability of any of the witnesses. For the avoidance of doubt I am satisfied that had I had to make that assessment I would have been satisfied that each and every witness should be treated as entirely reliable in what each said to the Inquiry.

[25] On that basis of fact I have made the determination that precedes this Note and that for the following reasons.

Section 6(1)(a)

[26] The time and place of Mr Rainey's death given in both the death certificate and the post mortem report are 15.41 hours on 12 April 2008 in the Victoria Infirmary, Glasgow. The time is when attempts to resuscitate him were ended and he was declared dead he having been transported by ambulance from Cathcart Police Office to the Infirmary. The family wish a different determination.

[27] On the evidence before the Inquiry I conclude that I must give effect to what is said in the death certificate. The accuracy of that is proved on the balance of probabilities by the evidence of the post mortem report, spoken to by Doctor Black, taken together with the evidence of those who strove to resuscitate Mr Rainey valiantly and tenaciously but, despite their commendable efforts and through no fault of theirs, ultimately unsuccessfully.

[28] I am not persuaded that I can or should give effect to the submission made for the family. It rests on two pillars. One is inferences that I should draw from the shreds of evidence led coupled with the opinion of Dr Morrison. I am not persuaded that I can draw any meaningful conclusion from the inferences even with that evidential assistance. The issue of timing and place of death was not explored in a way and to an extent that would enable me to draw the conclusion sought. In any event, even if I could have drawn the conclusion wished there was still the hurdle of applying to the inferences the second pillar,

the feature of judicial knowledge. The matter said to fall within this knowledge is that the longer a person's heart does not function the more likely it is that imminent death will result. What falls within judicial knowledge is, in general, matters which can be immediately ascertained from sources of indisputable accuracy or which are so notorious as to be indisputable. The matter urged does not fall within that category. It falls outwith judicial knowledge. It demands medical knowledge that no judge can be said to have by virtue of holding the office of judge. It requires evidence to establish the matter and that evidence was not before the Inquiry. For these reasons, I cannot give effect to the submission.

Section 6(1)(b)

[29] The cause of death lay at the heart of this Inquiry. It is given in the death certificate as "Undetermined". No other cause is noted. Dr Iles explained in the Conclusions section of her report her reasons for reaching this conclusion. In particular she mentioned in her summary that whilst no definite cause of death had been identified, there was no post mortem evidence of violence or injury contributing to his death, and given his history of alcohol abuse and seizures on abstinence, the circumstances surrounding his death and toxicological findings, the possibility that he died as a result of complications of alcohol withdrawal had to be considered. It was considered and it was not proved to be the cause of death. All interested parties who were represented at it have recognised this in their submissions. The evidence presented to the Inquiry, and which I accept, supported the cause of death was undetermined.

Section 6(1)(c)

[30] There was no evidence that justified a determination in terms other than formal.

Section 6(1)(d)

[31] There was no evidence that justified a determination in terms other than formal.

Section 6(1)(e)

[32] There was no evidence that justified a determination in terms other than formal.

APPENDIX ONE/

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1. Paul Rainey's date of birth was 23 March 1967.
2. Paul Rainey was pronounced dead at the Victoria Infirmary Hospital at 1541 hours on 12 April 2008.
3. At the time of his death Paul Rainey was abusing drugs and alcohol.
4. At the time of his death Paul Rainey was drinking approximately 3 litres of alcohol a day.
5. Paul Rainey had been dependant on alcohol for 20 years.
6. At times during the 20 year period prior to his death Paul Rainey had drunk up to 8 litres of alcohol a day.
7. Paul Rainey began using illicit drugs in the 1980's and became addicted to heroin in the late 1990's.
8. In 2006 Paul Rainey started a methadone programme.
9. At the time of his death Paul Rainey was prescribed 70ml of Methadone a day.
10. Paul Rainey had attempted to stop abusing alcohol and drugs, including attending rehabilitation at Jericho House in Greenock and another facility in West Street in Glasgow, without success.
11. Prior to his death Paul Rainey had suffered seizures. His sister, Helen Sweeney Rainey, witnessed Paul Rainey taking several seizures over a number of years. These were related to alcohol withdrawal. She witnessed one of these seizures in April 2006.

12. This seizure occurred after Paul Rainey had been withdrawing from alcohol.
13. Paul Rainey was hospitalised as a result of this seizure.
14. Prior to his death Paul Rainey had suffered seizures both whilst under the influence of drugs and alcohol and whilst withdrawing from alcohol.
15. Prior to his death Paul Rainey had received no medical treatment in respect of the seizures he had suffered.
16. Prior to his death, Paul Rainey had not been tested for epilepsy.
17. Elaine Rainey last saw Paul Rainey on 10 April 2008 when she considered he was under the influence of alcohol.
18. At approximately 1300 hours on Friday 11 April 2008 Paul Rainey was arrested by Constable Stewart Johnstone and Constable Allan McDowall.
19. Paul Rainey was arrested on authority of a District Court Warrant in respect of an unpaid fine of £100.
20. Upon his arrest, Paul Rainey was placed in handcuffs and appeared to be under the influence of alcohol.
21. Paul Rainey did not appear to be suffering from any medical complaints at the time of his arrest.
22. Paul Rainey cooperated with the arresting Officers.
23. The arresting Officers checked the Warrant System and confirmed that an Apprehension Warrant was outstanding in respect of Mr Paul Rainey regarding failure to appear at the District Court.
24. At this time, Paul Rainey was aware he would not be released from custody until after

appearing in Court on Monday 14 April 2008.

25. At approximately 1330 hours on 11 April 2008 Paul Rainey arrived at Cathcart Police Office.
26. In April 2008 Helen Street Police Office Custody Suite was closed for refurbishment.
27. All Police Officers and Police Custody and Security Officer who normally worked at Helen Street Police Office were working at Cathcart Police Office.
28. Paul Rainey was processed using the computerised Prisoner Processing System by Police Custody and Security Officer Louise McDonald.
29. Police Custody and Security Officer McDonald entered Paul Rainey's details into this electronic system.
30. This process took place in the presence of the arresting Officers and Sergeant David Bennie who was a Duty Officer on duty at Cathcart Police Office.
31. Police Custody and Security Officer McDonald asked Paul Rainey if he had taken drugs or alcohol and if he was suffering from any medical condition.
32. Paul Rainey advised Police Custody and Security Officer McDonald that he was on a prescription for 70ml of methadone a day but had not been able to obtain his prescription for a couple of days because he was "barred" from the Chemist.
33. Paul Rainey received his prescribed 70ml of methadone on 8 April 2008.
34. Thereafter, the Chemist who dealt with his methadone prescription refused to administer same to him.
35. If a prisoners prescription for methadone is available whilst he is in Police Custody it can be picked up from the appropriate Chemist and administered to the prisoner by a Casualty Surgeon.

36. During his detention at Cathcart Police Office on 11 and 12 April 2008, Paul Rainey's prescribed methadone was not available to him.
37. Paul Rainey did not advise Police Custody and Security Officer McDonald of any other medical conditions from which he suffered. He did not advise McDonald that he was an alcoholic.
38. Paul Rainey appeared to be under the influence of alcohol and Police Custody and Security Officer McDonald considered that he should be graded as having "had drink" as opposed to being "drunk".
39. Sergeant Bennie advised Paul Rainey of his rights including his rights to have a lawyer advised of his whereabouts and another appropriate person.
40. Paul Rainey asked that his Solicitor and his mother, Mrs Catherine Rainey, be advised that he was in custody at Cathcart Police Office.
41. Paul Rainey was searched by Police Custody and Security Officer Allan Donegan in the presence of the arresting Officers. Donegan noted that Paul Rainey was chatty and upbeat.
42. Paul Rainey was thereafter placed, by the arresting Officers, in cell 6 at Cathcart Police Office.
43. Duty Officer Sergeant Bennie decided that Paul Rainey required to be detained in custody at Cathcart Police Office until his appearance at Court on Monday 14 April 2008.
44. Prior to working as Duty Officers Police Officers attend a three day training course at the Strathclyde Police Office training Centre at Jackton.
45. Sergeant Bennie made this decision because Paul Rainey was the subject of an Apprehension Warrant.

46. Sergeant Bennie's decision was consistent with the Guidelines provided by the Lord Advocate in respect of the detention of prisoners in Police Custody.
47. Paul Rainey remained detained at Cathcart Police Office in cell 6 until approximately 1530 hours on 12 April 2008.
48. The care plan for Paul Rainey was that he was to be visited hourly and to be examined by the Casualty Surgeon when he visited Cathcart Police Office.
49. Duty Officers decide the care plan for each prisoner.
50. The arresting Officers were accompanied to cell 6 by Police Custody and Security Officer Donegan.
51. Paul Rainey made no complaint of feeling unwell.
52. Paul Rainey was compliant and cooperative with the Police Officers at Cathcart Police Office.
53. Sergeant Bennie placed Paul Rainey's name on the handwritten list of prisoners to be examined by the Casualty Surgeon who would be attending Cathcart Police Office later that day.
54. The Duty Officer decides which prisoners detained in Police Custody should be examined by the Casualty Surgeon when he visits the Police Office. Only prisoners on this list are examined by the Casualty Surgeon.
55. Casualty Surgeons contracted by Strathclyde Police are on call 24 hours a day.
56. Duty Officers can contact Casualty Surgeons at any time to seek advice or to request that the Casualty Surgeon attend the Police Office to see a prisoner as a matter of urgency.

57. Casualty Surgeons also attend Police Offices to examine prisoners who the Duty officer has decided should be examined by the Casualty Surgeon.
58. Casualty Surgeons always attend Cathcart Police Office at the weekend to examine prisoners.
59. The Duty Officer can also decide to send prisoners to hospital for medical attention.
60. This list of prisoners to be examined by the Casualty Surgeon was not recorded electronically or retained.
61. Sergeant Bennie added Paul Rainey to the list of prisoners to be examined by the Casualty Surgeon as result of Paul Rainey advising that his methadone prescription was not available.
62. At approximately 13:45 hours on 11 April 2008 Police Custody and Security Officer Lynn Docherty telephoned Paul Rainey's Solicitor and left a message on his answer phone advising of Paul Rainey's whereabouts.
63. Thereafter, Police Custody and Security Officer Lynn Docherty telephoned Mrs Catherine Rainey and spoke to Elaine Rainey. She advised Elaine Rainey that her brother was in custody and requested that she ask her mother to telephone Cathcart Police Office.
64. Between 1500 hours and 1600 hours on 11 April 2008 Elaine Rainey telephoned Cathcart Police Office and spoke to Police Custody and Security Officer Docherty. She advised Police Custody and Security Officer Docherty she had concerns for his health.
65. Elaine Rainey advised that Paul Rainey was an alcoholic, took seizures and was on a methadone programme.
66. Police Custody and Security Officer Docherty advised Sergeant Bennie of the contents of this telephone call.

67. Sergeant Bennie confirmed to Police Custody and Security Officer Docherty that he was aware that Paul Rainey was on a methadone programme but his methadone was not available.
68. Sergeant Bennie also advised that Paul Rainey was due to see the Casualty Surgeon later on that day at the Police Office.
69. Police Custody and Security Officer Docherty advised Elaine Rainey that Paul Rainey was going to be examined by the Casualty Surgeon and she could phone back at any time.
70. Sergeant David Bennie thereafter visited Paul Rainey in his cell.
71. Sergeant Bennie advised Paul Rainey that his family were asking for him and that they had told the Police about his previous history of seizures.
72. Paul Rainey advised Sergeant Bennie that he had had seizures in the past and was not on medication for same.
73. Paul Rainey also advised that he had not had any seizures recently.
74. Police Custody and Security Officers are employed by Strathclyde Police to provide inter alia for the care and welfare of prisoners who are in Police Custody.
75. This includes providing meals, processing details on the computer system, photographing and fingerprinting detainees, visiting prisoners and responding to any requests from prisoners.
76. Prisoners in Police Custody are visited at least on an hourly basis. The Officer visiting the prisoner is required to obtain a distinct verbal response from the prisoner.
77. These visits are carried out 24 hours a day. If sleeping, prisoners are roused during these visits.

78. Duty Officer can decide that prisoners should be visited more frequently than every hour.
79. At the beginning of their employment Police Custody and Security Officers are given a three week training course which includes organisational structure training, a First Aid Course, Police Custody and Security Officer specific training which includes identifying drug and alcohol symptoms, and the Prisoners – Custody Care and Welfare Standard Operating Procedure.
80. Prisoners – Custody Care and Welfare Standard Operating Procedure provides guidance to custody staff who care for prisoners detained in the custody of Strathclyde Police. Standard Operating Procedures are published on the Strathclyde Police Force Intranet available to all Police Officer and members of Police Staff and updated on a regular basis.
81. Prisoners in Police Custody are also visited by two Duty Officers at the beginning and end of each Duty Officer's shift. During all routine visits made to Paul Rainey a distinct verbal response was obtained.
82. During the routine visits made to Paul Rainey he did not complain of feeling unwell or ask for medical attention.
83. The Duty Officer coming on duty prints out a "C" Print and writes notes on this print out about each prisoner he visits.
84. A "C" Print details the name, criminal number, date of birth, cell number and the charge against each prisoner in custody at the time "C" Print is printed out.
85. The notes made on "C" Prints are not electronically recorded or retained.
86. Police Custody and Security Officer Allan Donegan visited Paul Rainey at approximately 1450 hours on 11 April 2008.
87. During this visit Police Custody and Security Officer Donegan opened the hatch of the

cell door and obtained a distinct verbal response from Paul Rainey.

88. Police Custody and Security Officer Donegan concluded that Paul Rainey was still under the influence of alcohol and awake.
89. Police Custody and Security Officer Donegan thereafter recorded his visit on the automated Prisoner Processing System as code “3” which means “had drink, awake”.
90. A visit to Paul Rainey was carried out by Police Custody and Security Officer Donegan at 1455 hours. He recorded this visit as code “3”.
91. Police Custody and Security Officer Donegan visited Paul Rainey at 1600 hours and recorded this visit as “4” meaning “had drink, asleep”.
92. At 1700 hours Paul Rainey was provided with, and accepted a meal, which was recorded on the Prisoner Processing System by Police Custody and Security Officer Lynn Docherty as code “20”.
93. Casualty Surgeon, Dr Paul Reid attended at Cathcart Police Office at approximately 1700 hours on 11 April 2008.
94. Dr Reid discussed with Sergeant Bennie the prisoners Sergeant Bennie wanted Dr Reid to examine including Paul Rainey.
95. During this discussion Sergeant Bennie told Dr Reid why he considered it appropriate that Dr Reid examined Paul Rainey.
96. At approximately 17.15 hours Police Custody and Security Officer Donegan accompanied Paul Rainey to the Casualty Surgeon’s room where Paul Rainey was examined by Dr Mark Reid.
97. Police Custody and Security Officer Donegan was not present when this examination took place.

98. Dr Mark Reid's note of his examination of Paul Rainey is timed at 17.17 on Friday 11 April 2008.
99. Paul Rainey identified himself to Dr Reid and advised that he had been arrested for drugs offences.
100. Paul Rainey advised Dr Reid that he was on a prescription for 70ml of methadone and had been on this dosage for several months.
101. Paul Rainey told Dr Reid that his last dose of methadone had been Thursday 10 April 2008.
102. Paul Rainey advised Dr Reid that his methadone prescription was not available to him.
103. Paul Rainey told Dr Reid that he had an alcohol dependency problem and was drinking approximately 3 litres of cider a day and his last alcoholic drink had been earlier on Friday 11 April 2008.
104. Paul Rainey told Dr Reid that he was on no prescribed medication and he had previously had a seizure problem but had never been on treatment for same.
105. Paul Rainey advised Dr Reid that he was suffering from drug withdrawal.
106. On examination Dr Reid found Paul Rainey to be smelling of alcohol, had a dry coated tongue, clammy skin and a pulse of 76 beats per minute.
107. Dr Reid found Paul Rainey to be aware of his situation.
108. Dr Reid noted his impression that Paul Rainey was not unwell at that time and still under the influence of alcohol.
109. Dr Reid prescribed 4x 30mg tablets of Dihydrocodeine to be dispensed at 2300 hours to Paul Rainey because his methadone was not available.

110. Dr Reid placed these tablets in a Dosset box provided by Strathclyde Police.
111. This Dosset box is divided into times and days of the week.
112. Dr Reid placed the Dihydrocodeine tablets into a space in the Dosset box associated with a timescale between 2100 and 2300 hours on Friday 11 April 2008.
113. Following his examination Dr Reid found Paul Rainey fit to be detained in Police Custody on hourly observations.
114. After examining Paul Rainey Dr Reid completed a Police Surgeons Examination Form.
115. After examining the prisoners Dr Reid discussed his findings with Sergeant Bennie.
116. Sergeant Bennie recorded the information Dr Reid gave him about Paul Rainey as a Duty Officers note.
117. This Duty Officers note stated “17.17 hours examined by Dr Reid is on methadone but states he is no longer welcome at the chemist and had not had his methadone.
- Prisoner states he is alcohol dependant, also states he has had seizures in the past but not recently. Not on meds.”
118. Dr Reid believed, based on standard procedure, that Paul Rainey’s condition would be re-assessed by another Casualty Surgeon on Saturday 12 April 2008.
119. Paul Rainey was returned to cell 6 at Cathcart Police Office by Police Custody and Security Officer Donegan at approximately 17.25 hours.
120. After Dr Reid’s visit the care plan for Paul Rainey was hourly visits and to be provided with the medication prescribed by Dr Reid.
121. Paul Rainey was visited by Mr Donegan at 1830 hours, 1930 hours and 2000 hours.

122. These visits were recorded in the electronic Prisoner Processing System as code “3”.
123. Between 1800 and 1900 hours on 11 April 2009 Elaine Rainey contacted Cathcart Police Office to enquire about the welfare of Paul Rainey.
124. During this telephone call Elaine Rainey was told that Paul Rainey had seen a Doctor and that he was fine.
125. At 2200 hours Paul Rainey was provided with 4x 30mg of Dihydrocodeine as prescribed by Dr Reid.
126. At approximately 2200 hours on 11 April 2008 Elaine Rainey telephoned Cathcart Police Office.
127. She spoke Police Custody and Security Officer Lisa Lindsay.
128. Elaine Rainey advised Lindsay Police Custody and Security Officer Lindsay that she had concerns for her brother.
129. Elaine Rainey advised Police Custody and Security Officer Lindsay that he was an alcoholic and had not had a drink that day.
130. Police Custody and Security Officer Lindsay checked the electronic Prisoner Processing System and noted that Paul Rainey had been examined by the Casualty Surgeon and formed the opinion that the information being provided by Elaine Rainey contained nothing in addition to that already recorded in the Duty Officers notes.
131. At 22:30 and 23:00 hours Paul Rainey was visited by a Police Custody and Security Officer. These visits were recorded in the electronic Prisoner Processing System as code “3”.
132. At 23:30 hours Paul Rainey was visited by a Police Custody and Security Officer. This visit was recorded in the electronic Prisoner Processing System as code “4”.

133. Between 2330 hours and midnight on 11 April 2008 Elaine Rainey's daughter contacted Cathcart Police Office enquiring about the welfare of Paul Rainey.
134. Ms Rainey was advised that Paul Rainey had been "barred" from his Chemist and would not be able to obtain methadone.
135. At midnight on 12 April 2008 Paul Rainey was visited by Chief Inspector William Carle who was the senior Officer on duty in 'G' Division at that time.
136. Chief Inspector Carle visited all of the prisoners in custody at Cathcart Police Office at that time. He also reviewed the reasons for their detention in Police Custody. He reviewed the duty officer's notes and the custody record and he was aware of Paul Rainey's condition.
137. When visiting Paul Rainey Chief Inspector Carle noted that Paul Rainey's hands were trembling slightly.
138. Paul Rainey advised Chief Inspector Carle that he was suffering from alcohol withdrawal. Carle arranged for Paul Rainey to be provided with a drink of water.
139. Chief Inspector Carle left instructions with Police Custody and Security Officer Gracie that if Paul Rainey's condition deteriorated a Doctor should be called to examine him.
140. Chief Inspector Carle did not record this information or his instructions to Police Custody and Security Officer Gracie in the Police Prisoner Processing System.
141. At 01:00 hours, 01:25 hours, 02:00 hours, 02:25 hours, 03:30 hours, 04:25 hours and 05:10 hours on 12 April 2008 Paul Rainey was visited by a Police Custody and Security Officer. These visits were recorded in the electronic Prisoner Processing System as code "4".
142. At 0600 hours on 12 April 2008 Paul Rainey was visited by Sergeant James Jamieson and Sergeant Stuart Dunsmuir.

143. Paul Rainey asked for a cup of water and was provided with same. Paul Rainey did not indicate that he was feeling unwell or required medical attention.
144. Sergeant Jamieson noted that Paul Rainey's hands were trembling slightly and assumed this was a result of alcohol withdrawal.
145. Paul Rainey's name was on the list of prisoners to be examined by the Casualty Surgeon when he visited Cathcart Police Office on Saturday 12th April due to his alcohol and drug withdrawal.
146. At 0715 hours on 12 April 2008 Paul Rainey was offered and accepted a meal.
147. At 08:20 hours on 12 April 2008 Paul Rainey left his cell in order to have a wash.
148. At 09:15 hours and 10:20 hours Paul Rainey was visited by a Police Custody and Security Officer. These visits were recorded in the electronic Prisoner Processing System as codes "3" and "4", respectively.
149. At 1100 hours on 12 April 2008 Paul Rainey was visited by the then Chief Inspector Kirk Kinnell. Chief Inspector Kinnell was the Senior Officer on duty in 'G' Division at the time.
150. Chief Inspector Kinnell visited all of the prisoners in custody at Cathcart Police Office at that time. He also reviewed the reasons for their detention in Police Custody.
151. Paul Rainey requested that Chief Inspector Kinnell ensure that he was examined by the Casualty Surgeon when he attended Cathcart Police Office on 12 April 2008.
152. Paul Rainey advised Chief Inspector Kinnell that he was "sweating" and that this was due to alcohol withdrawal.
153. At this time Paul Rainey was lucid and able to discuss the reasons for his detention with Chief Inspector Kinnell.

154. Chief Inspector Kinnell did not notice Paul Rainey visibly sweating at this time. Paul Rainey appeared to Kinnell to be jovial and relaxed.
155. Chief Inspector Kinnell ensured Paul Rainey's name was on the list to see the Casualty Surgeon when he attended at Cathcart Police Office on 12 April 2008.
156. At 1200 on 12 April 2008 Paul Rainey was offered and accepted a meal.
157. When being provided with this meal Paul Rainey asked Police Custody and Security Officer Samuel Hardie. Paul Rainey asked Hardie when he would receive his methadone.
158. Police Custody and Security Officer Hardie became aware that Paul Rainey's methadone prescription was not available.
159. Police Custody and Security Officer Hardie did not advise Paul Rainey of the situation regarding his methadone prescription.
160. At 12:53 hours on 12 April 2010, Paul Rainey was visited by Sergeant David Bennie. This visit was recorded as a code "1", meaning that Paul Rainey was noted to be awake and sober.
161. Dr Philip McNaught, Police Casualty Surgeon attended at Cathcart Police Office in the early afternoon of 12 April 2008.
162. Dr McNaught discussed with Sergeant Bennie the prisoners Sergeant Bennie wanted Dr McNaught to examine.
163. During this discussion Sergeant Bennie advised Dr McNaught why he considered it appropriate that Dr McNaught examine Paul Rainey.
164. At 14:05 hours Police Custody and Security Officer Donegan escorted Paul Rainey to the Casualty Surgeon's room where Paul Rainey was examined by Dr Phillip McNaught

165. Dr McNaught's medical note of his examination of Paul Rainey is timed at 14:10 hours on 12 April 2008
166. Paul Rainey reported to Dr McNaught that he had been detained on a Warrant and had been arrested on 11 April 2008.
167. Paul Rainey reported a history of drug abuse and that he was an alcoholic.
168. Paul Rainey told Dr McNaught that he was on 70ml of methadone a day but had no "live" script.
169. On examination Dr McNaught noted that Paul Rainey was tremulous++, sweating profusely and had a pulse rate of 76.
170. Dr McNaught diagnosed that Paul Rainey was suffering from drug and alcohol withdrawal and prescribed three times 60mg of Dihydrocodeine daily and 10mg of valium three times daily.
171. It is Dr McNaught's practice to place the medication he has prescribed to prisoners in the appropriate parts of the Dosset box after he has seen all of the patients he has been asked to examine.
172. Dr McNaught intended that Paul Rainey would be given the appropriate dosage of Dihydrocodeine and Valium once he had completed this process.
173. Dr McNaught found Paul Rainey fit to be detained in Police Custody on hourly observations.
174. After examining Paul Rainey, Dr McNaught completed a Police Surgeon's Examination Form.
175. Paul Rainey was thereafter escorted back to cell 6 at Cathcart Police Office by Police Custody and Security Officer Donegan.

176. Whilst escorting Paul Rainey to and from his cell Police Custody and Security Officer did not note Paul Rainey trembling or looking unwell.
177. At approximately 1450 hours on Saturday 12 April 2008 the buzzer within the bar area sounded in respect of cell 6 of Cathcart Police Office.
178. Police Custody and Security Officer Donegan immediately attended at cell 6.
179. It took approximately 30 seconds from the buzzer sounding for Donegan to reach cell 6.
180. Police Custody and Security Officer Donegan opened the hatch of the cell door and saw Paul Rainey lying still on the floor of the cell on his right hand side.
181. Police Custody and Security Officer Donegan could not illicit a response from Paul Rainey and ran to the bar area to obtain keys for cell 6.
182. Police Custody and Security Officer Donegan advised Inspector Ian Wilson, who was in the bar area, that he was concerned about Paul Rainey and Inspector Wilson accompanied him to cell 6.
183. Inspector Wilson and Police Custody and Security Officer Donegan entered cell 6 and found Paul Rainey lying motionless on the floor of the cell.
184. Inspector Wilson and Police Custody and Security Officer Donegan found Paul Rainey to be breathing and to have a faint pulse.
185. Neither Officer could obtain a response from Paul Rainey.
186. Paul Rainey was placed in the recovery position and his airway was checked and found to be clear. Donegan noted that Paul Rainey was sweating and his face was red. There was some saliva coming from his mouth.
187. Inspector Wilson left cell 6 to telephone for an ambulance and Police Custody and

Security Officer Donegan continued to try obtain a response from Paul Rainey.

188. Police Custody and Security Officer Donegan attracted Sergeant Bennie's attention who instructed Police Custody and Security Officer Donegan to go and get Dr McNaught.
189. Dr McNaught was still in the Police Casualty Surgeon rooms arranging the medication he had prescribed into the appropriate dosset boxes.
190. Dr McNaught attended at cell 6 where an examination of Paul Rainey ascertained that he had no pulse and was not breathing.
191. Dr McNaught looked for a protective mask to use whilst giving CPR but could find one.
192. Dr McNaught began cardio pulmonary resuscitation on Paul Rainey as soon as he realised a mask was not available.
193. This consisted of both mouth to mouth resuscitation and chest massage.
194. Dr McNaught continued giving CPR to Paul Rainey until an ambulance arrived at Cathcart Police Office at 1503 hours.
195. It takes approximately four minutes to drive from the ambulance Station to Cathcart Police Office.
196. Sean McGranagan, paramedic asked Dr McNaught to continue with CPR whilst he made basic airway/breathing/circulation checks on Paul Rainey.
197. Mr McGranagan found Paul Rainey's airway to be clear but no circulation and an absence of breathing and pulse.
198. Mr McGranagan secured Paul Rainey's airway whilst Dr McNaught continued chest compressions.

199. Mr McGranagan attached defibrillator pads to Paul Rainey's chest and noted that the defibrillator detected fine ventricular fibrillation.
200. The defibrillator then automatically administered a shock to Paul Rainey.
201. The defibrillator analysed Paul Rainey's heart and found it to be asystole.
202. Paul Rainey was then transferred to an ambulance which departed the police station at 15:19 hours.
203. Mr McGranagan and his colleague continued to administer cardiopulmonary resuscitation to Paul Rainey until his arrival at Victoria Infirmary. They did not detect any signs of Paul Rainey's heart re-starting after the defibrillator detected asystole.
204. Paul Rainey was pronounced dead at the Victoria Infirmary at 1541 hours on 12 April 2008.
205. Edward Rainey, Paul Rainey's brother attempted to contact Cathcart Police Office on Saturday 12 April 2008 at approximately 1530 hours. He was unable to do so as he was dialling an incorrect number.
206. At approximately 1540 hours on 12 April 2008 Inspector Graham Wilson telephoned Catherine Rainey and spoke to Elaine Rainey.
207. Inspector Wilson advised Elaine Rainey that Paul Rainey had been found lying unconscious in a police cell and had thereafter been taken to Victoria Infirmary.
208. On Saturday 12 April 2008 Elaine Rainey attended the Victoria Infirmary where she was advised that Paul Rainey has passed away.
209. On 17 April 2008 a post mortem examination was carried out on Paul Rainey by Dr Linda Iles.

210. During this Post Mortem Dr Iles found no post Mortem evidence of violence or injury contributing to Paul Rainey's death.
211. In her Post Mortem Report dated 27 May 2008 Dr Iles found the cause of Paul Rainey's death to be unascertained.