

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

*Inquiry held under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976
Section 1(1) (a)*

DETERMINATION OF Sheriff Frank Richard Crowe

into the death of ANGELA SMITH

EDINBURGH 22 December 2009

Introduction

[1] This inquiry relates to the tragic death of a 28 year old mother of two young children who died when in police custody on 26 January 2008. The inquiry took place at Edinburgh Sheriff Court and evidence was heard on 19 days between 22 September and 29 October 2009. In addition a locus visit to the custody suite at St. Leonard's Police Station, Edinburgh took place on 12 October. There were also two days (18 and 19 November 2009) when, after written submissions were lodged, oral submissions were made.

[2] Evidence for the Crown was led by Mrs. G More, Senior Procurator Fiscal Depute. The family of Angela Smith was represented by Mr. A Milne, Solicitor of Messrs. Balfour and Manson, Solicitors Edinburgh. Lothian and Borders Police was represented by Mrs. E. Swanson, Solicitor Advocate of Messrs. Maclay, Murray and Spens LLP, Solicitors, Glasgow and Lothian Health Board was represented by Mr. V Khurana, Advocate instructed by Mrs. N Shippin of the National Health Service.

[3] Evidence was led from the following witnesses:-

1. Detective Constable Robert Campbell
2. Constable Tricia Said
3. Constable Mhairi Mitchell
4. Constable Andrew Couillard
5. Constable Colin McDonald
6. Sergeant William Stevenson
7. Constable Neil Marr
8. Police Custody Support Officer Avril Gallagher
9. PCSO Donna Montgomery
10. PCSO Elizabeth Leitch
11. PCSO Lorraine Marjoriebanks all Lothian and Borders Police, Edinburgh
12. Nurse John Madden, Lothian Health Board
13. Professor Kevin Gournay, CBE, King's College, London
14. Sergeant Keith Wilson, Lothian and Borders Police, Edinburgh
15. Nurse Dawn Gourlay, Lothian Health Board
16. Dorothy Hughes, Pharmacy Department, Western General Hospital,

Edinburgh

17. Nurse Melanie Logan, Lothian Health Board
18. Sergeant Christopher Paget, Lothian and Borders Police, Edinburgh
19. Esther Rutherford
20. Susan Ward
21. Craig Henderson all Scottish Ambulance Service, Edinburgh
22. Sergeant Bryan Jones, Lothian and Borders Police Edinburgh
23. Kim Crawford
24. Dr. Charles Sanderson
25. Dr. Michael Kaim
26. Professor Anthony Busuttil all NHS Lothian
27. PCSO John Neilands
28. Constable Hazel Parker
29. Detective Chief Superintendent Malcolm Graham, all Lothian and Borders Police, Edinburgh
30. Dr. Samantha Perry Western Infirmary, Glasgow
31. Shareen Fleming c/o Lothian and Borders Police
32. Dr. James Grieve, Dept. of Forensic Medicine, University of Aberdeen
33. Chief Inspector Kevin Greig Lothian and Borders Police, Edinburgh
34. Professor Derrick Pounder Dept. of Forensic Medicine, University of Dundee
35. Chief Inspector Anthony Beveridge, Lothian and Borders Police Edinburgh

Findings in Fact

[4] I found the following facts admitted or proved:-

1. Angela Smith was born and brought up in Edinburgh by her parents in a comfortable and loving environment. She had an older sister and younger brother. Angela left school at 16 and worked with an insurance company in Edinburgh. Her talents were immediately recognised and she was promoted quickly. She had a bright career ahead of her. Sadly she was introduced to illicit drugs by boyfriends and for the last 8 or 9 years of her short life struggled to cope with a drug problem which involved the smoking of heroin and the abuse of cocaine and dyhydrocodeine tablets. There was a spell where Angela made great strides to wean herself off drugs by her involvement in a drug rehabilitation course and avoiding the drugs scene. Unfortunately she returned to previous ways and in the 6 months prior to her death lost a significant amount of weight as a result of drug abuse and failing to look after herself. Despite all of these problems Angela was a polite cheery person who behaved impeccably when dealt with by the police officers and support staff in the last 36 hours of her life.
2. Based on information gathered, Constable Robert Campbell obtained a warrant from Edinburgh Sheriff Court on 18 January 2008 under the Misuse of Drugs Act 1971 to search the house at 8/8 Southhouse Square occupied by Angela Smith and another. The warrant was executed shortly before 11am on Friday 25 January 2008 by Constable Campbell who was assisted by Constables Said, McDonald,

Mitchell, Marr and Couillard. The search operation was overseen by Sergeant Stevenson.

3. Two adult males were found in the living room of the house and quantities of diamorphine totalling about 7 grammes were recovered. This quantity of diamorphine was worth about £700 on the black market. The paraphernalia and remnants of smoking diamorphine were recovered together with diamorphine-contaminated scales, tick lists and cut bags, indicative of preparation to distribute the drug. A CCTV system was recovered which enabled persons sitting in the living room of the house a view on the television set of the main door of the block of flats in which the house was situated. £450 of money was recovered from one of the males. Angela Smith was found in a bedroom apparently asleep. Three wraps of diamorphine one weighing 150 mgs. and another weighing 116 mgs. were recovered from her bed. The other bag of diamorphine was of a similar size. £660 of cash was recovered from this room as well as a cut bag which was found in the rear pocket of a pair of jeans. Over 200 dihydrocodeine tablets and loose powder were recovered in the house as well as 53 Diazepam tablets. Angela Smith was strip searched with negative results and the clothes she was wearing at that time were searched in the house twice. She denied having drugs secreted internally. Angela Smith had no drugs in her clothing or empty bags of drugs in her clothing at this time.
4. Angela Smith and the two males were conveyed to St Leonard's Police Station arriving at about 2pm on 25 January. Angela Smith was searched at the Charge Bar of the police station and the search was recorded on CCTV. Angela had put on extra clothing prior to being taken to the police station. Her socks were not searched again at the police station nor was she re-searched by custody staff prior to being placed in a cell by PCSO Leitch. Cell B32 in which Angela was kept while in custody at St Leonard's Police Station had not been searched immediately prior to Angela being placed in it. In addition Angela Smith was not shown how to use the buzzer which is located in the cell for use when the prisoner needs assistance.
5. In conversations with Constables Mitchell and Said at her home prior to being taken to the police station Angela Smith said that she took 2 or 3 £10 bags of diamorphine a day and valium and dihydrocodeine tablets. She confirmed to the officers she had lost weight recently and it was noted that Angela Smith had nutrient drinks in the house to alleviate weight loss and anemia.
6. At the charge bar at St Leonard's Police Station Angela Smith denied having a drug problem but told PCSO Leitch and Constable McDonald that she took 6 x 30 mg. dihydrocodeine tablets per day and smoked heroin twice per week but had not taken any such drugs that day. Constable Mitchell then completed an At Risk form which identified Angela Smith as having a drug dependency involving the taking of 8 x 30ml dihydrocodeine and heroin occasionally. Angela Smith was compliant during these procedures and was fit to be detained.
7. During the afternoon of 25 January Angela Smith was interviewed by Constables Campbell and Said in relation to items and money recovered at her house and was arrested and charged with drugs supply offences. During the interview Angela

Smith said she took eight 30ml dihydrocodeine tablets and two £10 bags of diamorphine each day.

8. The cell area is overseen by a police inspector who works day time shifts. In practice the running of the unit and the welfare of the prisoners is the responsibility of the duty sergeant in terms of police internal guidance. The duty sergeant should see each prisoner who is placed in a cell, either on arrival or as soon as possible thereafter. The duty sergeant should see each prisoner at the start and end of the shift. The cells are located in a secure part of St Leonard's police station and prisoners spend the majority of time locked in there until such time as they are either released, sent to court or transferred elsewhere. While in the cells it is the duty of custody staff to check that prisoners are fit and well.
9. CCTV is in operation at the Charge Bar area and cell corridors. It is a digital recording system and the data is stored on hard drives located in the police station. A bank of monitors showing live footage from the various camera positions is located in the duty sergeant's room. Observations can be increased if the sergeant considers it appropriate and prisoners can be put in an observation cell if suicide or self harm is considered likely. Such cells contain CCTV cameras for continuous monitoring. A single television monitor displays the view in the observation cell; other camera shots are shown in sections of four or six on monitors with consequently reduced clarity. There are, in addition, special cells to monitor prisoners suspected of having swallowed or secreted quantities of controlled drugs.
10. Each camera in the CCTV system records the time footage was taken. The camera times were slower than actual time but the correct times are shown on the legend (Production No. 33) which was compiled of the CCTV footage.
11. Angela Smith had nothing to eat or drink from when she was wakened by the police about 11am on 25 January until given tea in the cells at St Leonard's police station at 5 28pm that day which consisted of a 200 ml cup of tea, a sandwich, a chocolate bar and an apple.
12. Angela Smith was not seen by the duty sergeant in the custody suite when she was brought to St Leonard's police station nor was she seen by subsequent duty sergeants at the beginning and end of their shifts. The only time Angela Smith was seen by a duty sergeant was in her cell after her death. No drug test was carried out on Angela Smith as should have happened when she was taken into custody at St Leonard's
13. Angela Smith's custody status was reviewed each shift by the duty sergeant. Angela Smith's continued incarceration in police custody, after arrest along with her co-accused for the next sitting of Edinburgh Sheriff Court to be held on 28 January 2008, was in compliance with the Lord Advocate's Guidelines to Chief Constables re Liberation by the Police of persons held in custody as she faced serious allegations of dealing in controlled drugs. There was a sufficiency of evidence for police to report a case against Angela Smith to the Procurator Fiscal for being concerned in the supply of controlled drugs.
14. Instructions were given by the duty sergeant on duty on the afternoon of 25 January that Angela Smith should be seen by a nurse in the custody suite in view of the At Risk form. No specific decision was made about the frequency of

- observations and accordingly, in terms of the default arrangements Angela Smith required to be observed each hour by custody staff. No other details regarding Angela Smith were passed on to successive shifts of custody staff. Undue weight was placed on her compliance and quiet demeanour rather than monitoring her risk status.
15. Since 2006 there has been in place in the Lothian and Borders Police area a service where nurses are located within the St Leonard's cells complex and are on hand to examine and treat prisoners, the majority of whom present with risk factors including drug and or alcohol abuse and consequent withdrawal symptoms as well as minor injuries. This enables prisoners to be treated without the need to take them to the Casualty Department of the local hospital unless the prisoner's condition gives concern and is deemed to be unfit to be detained. In early 2008 nurses were on duty each weekday night from 7pm and continuously through the weekend. Two nurses should be on each shift but occasionally due to illness or calls elsewhere a single nurse might be in attendance. This nursing service was supported by Forensic Medical Officers who are qualified doctors. They attend the cells area several times a day to hold clinics of examine prisoners. FMOs had other duties elsewhere in the police force area and might have to be contacted on the telephone to give advice and prescribe drugs.
 16. Custody staff were aware that Angela Smith required to be seen by the nurse and when Nurse Gourlay came on shift at 7pm on 25 January she made up a list of prisoners who required to be seen. She arranged to see the male prisoners first and then another female prisoner as she was working alone that night. PCSO Gallagher advised later her against seeing Angela Smith that night as Angela was "sleeping and alright". The duty sergeant was not aware that this decision had been taken but no mention was made of Angela Smith's case at the handovers of sergeants and custody officers.
 17. PCSO Gallagher observed Angela Smith in her cell on 15 occasions on the night on 25 and 26 January 2008, each observation being by the spy hole in the cell door, said observations being of about one second duration. On one of the occasions there was an initial unauthorised observation by a male custody officer.
 18. At 7 05am on 26 January 2008 PCSO Leitch observed Angela Smith through the spy hole and noticed that she had been sick. It is not known when Angela Smith had been sick other than it was sometime between 5 42pm on 25 January and 7 05am on 28 January. This fact was not noted on the custody record after observation by PCSO Leitch nor brought to the sergeant's attention. Angela Smith was asleep at this time. PCSO Leitch had an arrangement with her supervisor, PCSO Marjoriebanks that she would clear up prisoners' vomit. This was not done until 9 20am which was an unacceptable delay. Around this time Angela Smith was shown the buzzer in her cell by PCSO Marjoriebanks and told to ring it should she require assistance.
 19. At 9 12am Angela Smith was examined by Nurse Madden and Nurse Logan. Angela Smith was assessed having the symptoms of moderate drug withdrawal and was given 6mgs. of Bucasten to prevent further sickness and 60mg. of Dihydrocodeine to combat the effects of drug withdrawal. She was fit for her detention to continue. These drugs were supplied without the appropriate

- authorisation from a doctor as none could be contacted by the nurses on the telephone. Angela Smith was observed briefly through the spy hole at 10 02, 11 04 and 11 22.
20. Angela Smith had refused breakfast and at 1205 refused lunch. She had spoken briefly to PCSO Supervisor Neilands at 10 45 and was able to give coherent information to him in answer to any enquiry about one of her children.
 21. At 12 20pm Angela Smith was given a further 60mg tablet of dihydrocodeine. She told Nurse Madden and PCSO Leitch that she was feeling better. Angela Smith remained fit to be detained in custody. Around 12 40 Nurse Madden saw Dr Kaim, one of the Forensic Medical Officers who considered Angela Smith's case by looking at the nursing notes and on being advised she was better decided not to examine her personally and retrospectively approved the prescriptions for dihydrocodeine and if necessary Bucasten.
 22. At 1 25pm PCSO Marjoriebanks spoke to Angela Smith at her cell and offered her a newspaper to read but this was declined. Angela Smith was observed at regular intervals by custody staff through the spy hole on the afternoon of 26 January at 2 34, 3 19, 4 21, 4 25 and 4 40pm. These observations were very brief and it was noted that Angela Smith was resting and appeared well.
 23. At 5 09pm Angela Smith accepted and was given a meal consisting of a cup of tea, a cheese roll, an apple and a chocolate bar. Angela Smith drank the tea and partially ate the chocolate bar. At 5 38pm Angela Smith was given a 60 mg dihydrocodeine tablet and a cup of water by Nurse Logan and PCSO Leitch. Angela Smith said. No traces of vomit were seen in the cell at this time. Angela Smith remained fit to be detained at this time. During her time in custody Angela Smith consumed only about 600ml of fluid. This is about a quarter of a healthy intake for an adult. Matters were exacerbated by loss of fluid through vomiting. The human body can withstand significant fluid balance for several days and will retain fluid, normally excreted, if not replaced.
 24. At 6 26pm PCSO Leitch observed Angela Smith briefly through the spy hole and door hatch of her cell spoke to her and noted her as appearing well. At 6 55pm, after coming on shift PCSO Montgomery spoke to Angela Smith through the cell hatch and received an acknowledgement.
 25. Subsequently PCSO Montgomery observed Angela Smith through the cell door spy hole at 8 06, 9 04, 10 13 and 11 07 pm. Although the cell light was illuminated on each occasion the observations were no more than one or two seconds duration. After each observation Angela Smith was noted as "sleeping, appears well". At five feet five inches tall PCSO Montgomery was too small to see anything through the spy hole other than Angela Smith lying on the raised bed area of the cell. Without dropping the hatch which she did not do after 6 55 pm she could not see whether Angela Smith had been sick.
 26. At 11 47 pm PCSO Montgomery and Nurse Logan attended at Angela Smith's cell to give her a further dihydrocodeine tablet. Angela Smith could not be wakened and Nurse Gourlay entered the cell at 11 48 followed by PCSO Montgomery. Angela Smith could not be roused and an emergency call was made by the duty sergeant. Cardio pulmonary massage was commenced by Nurse

Logan and continued by Dr Sanderson, one of the Force Medical Examiners who was in the police station.

27. At 11 56 pm Paramedics Ward and Henderson arrived at the cell and assisted with resuscitation. They were joined by Paramedic Henderson at midnight. Post mortem staining was found on the back and arm of Angela Smith and in terms of their protocols for such situations the paramedics ceased further resuscitation procedures. Dr Sanderson ceased CPR a few minutes later and pronounced Angela Smith's life extinct at 12 02 am on 27 January 2008.
28. It was clear to Nurse Gourlay and PCSO Montgomery on entering the cell that Angela Smith was dead at 11 48 pm and had been so for some time. Custody staff were unable to advise the paramedics when Angela Smith had last been seen alive. PCSO Montgomery's observations of Angela Smith after 6 55 pm were perfunctory and at best were based on a recollection that Angela Smith must have moved since the last observation and therefore was sleeping but alive. PCSO Montgomery was clearly shocked after finding Angela Smith dead and was sent home from duty later that night. She was unable in the circumstances to give a coherent account of Angela Smith's condition between 6 55 pm and 11 48 pm.
29. Angela Smith died between 6 55 pm and 10 13 pm on the evening of 26 January 2008 within cell B32 at St Leonard's Police Station. She had had a recurrence of drug withdrawal sometime after 6 55pm and was sick in the cell toilet and a sick bowl. Angela Smith then lay down on her bed in the cell and sometime thereafter died of a heart attack. Her heart had been damaged by previous abuse of cocaine and diamorphine. Inhalation of vomit was not a factor in her death but some gastric contents found their way post mortem into Angela Smith's airways as a result of vigorous CPR which took place some time after her death. She had chronic bronchitis and emphysema from smoking heroin and permanent damage to her lungs. This had an adverse effect on the right side of her heart.
30. About 1 20 am on 30 January 2008 Detective Constable Higginbottom and Detective Inspector Mikkelsen carried out an examination of cell number B32 in which Angela Smith died. On examination of the toilet bowl they removed a piece of white substance which was found floating on top of the bowl. This was the remains of the dihydrocodeine tablet which Angela Smith had been given at 5 38 pm on 26 January. The officers found the prisoner buzzer system and cell lights of cell B32 to be in working order.

The Sheriff having considered the evidence adduced and submissions thereon, **DETERMINES** in terms of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976

1. That, in terms of section 6(1) (a), Angela Smith, born on 22nd December 1979, latterly of 8/8 Southhouse Square Edinburgh, died within cell B32, St. Leonard's Police Station, Edinburgh between 18 55 and 22 13 hours on 26th January 2008.
2. That in terms of section 6(1) (b) the cause of death was:-
 - 1 (a) Coronary arthrymnia
 - (b) Myocardial fibrosis and chronic emphysema

(c) Misuse of cocaine and opiates

3. That in terms of section 6 (1) (e) the following circumstances were relevant to the circumstances of Angela Smith's death:-

(i) That in reviewing the continued detention of Angela Smith the duty sergeants concentrated on whether she should remain in custody in terms of the Lord Advocate's guidelines and had no information that Angela Smith was unfit to be detained. No re-assessment of Angela Smith's at-risk was carried out and systems in place precluded the proper flow of vital information to exercise proper discretion in this context.

(ii) Cell observations made on Angela Smith were in general cursory and were not of sufficient quality to determine whether the prisoner was alive and well.

(iii) Having identified that Angela Smith was at-risk due to a dependency on illicit drugs a medical assessment was delayed, no care plan for treatment of drug withdrawal drawn up and no formal re-assessment carried out to find out whether the prescribed treatment was working.

and further RECOMMENDS

- (a) Additional training is devised for custody staff to ensure proper quality observations are made on prisoners to ensure their continuous safety and well-being while in custody.
- (b) Nursing staff should be integrated fully into the custody suite to enable them to give advice on the nature of observations to be made on at-risk prisoners and be able to have prompt access to such prisoners on cause shown to execute care plans drawn up for at-risk prisoners.
- (c) Police guidance on whether to continue the detention of a prisoner should be reviewed to ensure the status and condition of any at-risk prisoner is regularly reviewed based upon information supplied by custody staff and personal observation and contact by the determining officer.

NOTE

Introduction

[5] A number of issues were raised in this Inquiry, some of which were resolved in the course of the evidence and submissions. A number of matters remain which are outwith the scope of a fatal accident inquiry conducted under the 1976 Act and related legislation. I shall deal with all of the complaints raised but restrict my conclusions to the framework set down in section 6 of the 1976 Act.

Determination

Section 6 (1) (a) when and where the death took place

[6] Although Angela Smith's life was formally pronounced extinct at 12:02 am on 27 January 2008 by Dr Charles Sanderson, Forensic Medical Examiner it was clear from the evidence of Nurse Gourlay and PCSO Montgomery that when they entered Angela

Smith's cell at 11 48 pm on 26 January she was already dead and had been so for some time. It was submitted on behalf of Lothian and Borders Police and the NHS that time of death should be between the time of the last observation of Angela Smith prior to finding her dead in her cell namely 11 05 and 11 45 pm. This contention is in line with what would be the expected position in a case of this type.

[7] IH B Carmichael in "Sudden Deaths and Fatal Accident Inquiries" (3rd Edition) para 5-65 at page 167 states:-

"In the case of deaths occurring where the deceased was in legal custody,... establishing the time..of deaths should occasion little difficulty, ...where the deceased...has been kept under the requisite degree of surveillance."

On the evidence before me I could place no reliance on the last few observations of Angela Smith in her cell prior to her being discovered dead nor could I accept the custody log entries in particular the one at 11 05 pm that Angela Smith was sleeping and well.

[8] Contrary to the evidence of Detective Sergeant Mikkelsen and Detective Constable Paterson who compiled the legend based upon the analysis of custody suite CCTV footage (No. 33 of process) I preferred PCSO Montgomery's evidence that at 6 55 pm when coming on shift she spoke to Angela Smith through the cell hatch and received an acknowledgement. I also accept that at that time there were no obvious signs of vomit in Angela Smith's cell. I was not however satisfied with PCSO Montgomery's evidence concerning the hourly checks she made on Angela Smith at 8 06, 9 04, 10 13 and 11 17 pm. Each observation was a perfunctory one made through the spy hole and was of no more than two seconds duration.

[9] Professor Pounder opined that an observer would need to look at a sleeping person for around four seconds to be satisfied the person was still alive and breathing properly. PCSO Montgomery at five feet five inches was the smallest of the custody staff who gave evidence. She said she could only see an individual resting on the raised bed area of the cell through the spy hole and consequently since she did not drop the cell door hatch to get a better view had no opportunity to notice or smell any vomit there might had been in the cell at these times or form a proper assessment as to the condition of Angela Smith.

[10] The entries which PCSO Montgomery made in the custody record (No. 14 of process) after these short viewings were all to similar end "Sleeping, appears well". It was apparent from the CCTV footage the great shock experienced by PCSO Montgomery when she discovered Angela Smith at 11 48pm apparently dead. PCSO Montgomery had to go home early that night as she was in a state of shock and extremely upset. My view was that PCSO Montgomery was unable to give reliable evidence about her observations on Angela Smith after the first one when she commenced her shift and spoke to Angela Smith. She said that she had detected movement from Angela Smith each time she carried out the subsequent observations probably because each time she put on the cell light to see inside more clearly and this caused movement. PCSO Montgomery also said that Angela Smith had changed her position on each occasion from the one she saw her sleeping in previously and was "happy with that". PCSO Montgomery said that she could not see "any flaw when looking through the peephole". PCSO Montgomery's recollection was that Angela Smith had been found at 11 47 pm lying on her back on the bed in the cell with her head to the left and facing upwards and feet to the right hand side of the

room. At the previous observation at 11 17pm Angela Smith been in a similar position on the bed lying on her back with her head facing the rear wall. At 10 06 pm PCSO Montgomery said that Angela was sleeping in a different position with her head facing the cell door. Her evidence regarding the 8 06 and 9 14 pm observations was that “she would have made sure she was sleeping”.

[11] I found the evidence of Shareen Fleming unreliable but not incredible. She had been arrested on 25 January following a police search of her home for drugs. She was transferred to St Leonard’s and housed in the next cell to Angela Smith until moved elsewhere in the cell complex when Angela Smith was found dead. Shareen Smith spoke about the girl in the next cell [Angela Smith] being violently sick and crying for about an hour about 5 pm on 26 January but by that stage had been in custody for some time. She had been trying to sleep off the effects of drug withdrawal herself and her idea of the time cannot be precise. She said after the girl was sick she fell asleep, heard a commotion, fell asleep then was transferred to another cell presumably when Angela Smith’s body was discovered. Ms Fleming asked if the girl [Angela Smith] was alright. She heard one of the staff enquiring if the prisoner was alright and offered a glass of water. Shareen Fleming did not consider ringing her buzzer on behalf of the next cell inmate and fell asleep shortly afterwards. It is difficult to equate this evidence to any specific time based on the evidence before the court. If Angela Smith was sick around 5pm on 26 January she had several opportunities to complain to staff either by ringing the buzzer or when given her tea and medication and spoken to by PCSO Montgomery. The contact with Angela Smith by custody staff at these times was adequate enough to spot or smell vomit. Consequently my impression of Shareen Fleming’s evidence is that she spoke to an incident of vomiting some time after 7pm on 26 January and given her circumstances cannot be accurate about its duration.

[12] Compared to some of the other custody suite witnesses I did not think PCSO Montgomery was a bad witness. She was the youngest of the officers who gave evidence and was clear about what she had been taught when becoming a PCSO in June 2006. It was clear too after her experience of finding Angela Smith dead in her cell she had changed her practice to take more careful observations. The problem with her evidence for this crucial period was that the quality of the observations between 7pm and 11 45 pm was that they were so fleeting and the notes made on the custody record repetitive and formulaic that she was unable to say clearly to colleagues and the paramedics when she had last definitely seen Angela Smith alive after her contact when coming on shift at 6 55pm.

[13] Against this evidence was the evidence of the paramedics and Dr. Sanderson who found post mortem lividity staining on Angela Smith’s back and arm which was suggestive that death had occurred a considerable time prior to her discovery at 11 47 pm. Similarly they could find no vital signs when Angela Smith was connected to the resuscitation equipment which would have detected some electrical activity in the heart even after the patient is clinically dead. For some unexplained reason no deep rectal temperature was taken from Angela Smith when her body was examined in the cell in the early hours of 27 January. Without such a key indicator all of the pathology witnesses were loath to fix a precise time of death. When pressed Dr. Grieve said that in light of the evidence of post mortem staining it was “difficult” to accept that Angela Smith could

have been alive at the observation carried out at 11 07 pm but he could “cope with” her still being alive at 10 13 pm.

[14] Professor Busuttil was of the view that post mortem staining appears around 3 hours after death. Professor Pounder who has considerable experience in considering deaths in custody both in the United Kingdom and abroad homed in on the inadequately brief observations after 6 55pm. His view was that it was necessary to view (and listen) to a sleeping prisoner for at least four seconds before being able to say he or she was sleeping and alright”. Professor Pounder’s view having considered all of the evidence was that it was not possible to give a timing of death other than to fix on the period between last seen alive and when found dead.

[15] Accordingly I prefer the other evidence and circumstances on this point to the evidence given by PCSO Montgomery. I found her credible and reliable that she spoke to Angela Smith at 6 55pm and received an affirmative response and that when she entered the cell at 11 48pm Angela Smith was already dead. Unfortunately I found her evidence of the brief observations made between these times not to be reliable and of insufficient duration and quality to indicate whether Angela Smith was alive at these times. As I have indicated above the medical evidence all points to Angela Smith having been dead for at least one and a half hours and probably more before she was found at 11 48 pm. In light all of the other evidence there was no dispute that Angela Smith had been found dead in cell B32 at St Leonard’s Police Station on 26 January 2008.

Section 6 (1) (b) causes of death

[16] Although the report of the autopsy on Angela Smith carried out by Professor Busuttil and Dr. Arango (No. 1 of Process) and the supplementary report prepared by Dr. Arango in light of histology and toxicology results (No. 2 of process) with which Professor Busuttil agreed concluded that Angela Smith’s cause of death was:-

I (a) Inhalation of gastric contents

II Misuse of cocaine and opiates

the weight of evidence was against this formulation.

[17] Dr. Grieve and Professor Pounder were of the view that there was insufficient tissue damage which is usually seen when death is caused by inhalation of vomit for this to have been a factor. There was evidence from Nurse Gourlay and Dr. Sanderson about the need to clear Angela Smith’s airway of fluid before continuing CPR. I formed the view that the medical evidence taken with the evidence that vigorous CPR was carried out on Angela Smith for about 15 minutes at a time when she was dead was likely to have caused stomach contents to have been pumped up during this process.

[18] Professor Busuttil and Dr. Arango had found no obvious signs at autopsy to give a cause of death and were only able to provide conclusions after a histological examination of samples of tissue they did notice signs of emphysema in the lungs and the signs of smoking cannabis and diamorphine over a period of time. In addition they found evidence of cocaine and opioid use affecting the heart. These findings were amplified by Dr. Grieve and Professor Pounder following their examination of the histology slides and other reports. Once again the weight of evidence was that unbeknown to Angela Smith or anyone else her 10 year drug problem had damaged her heart and the most likely cause of

death was that Angela Smith had suffered a sudden and severe heart attack at some time after being sick on the evening of 26 January and died.

Causation of death

[19] Dr. Grieve postulated a theory of dehydration based upon the remarkably low level of fluid given to Angela Smith while in police custody. This was exacerbated by Angela Smith having been violently sick on at least two occasions. Ultimately Dr. Grieve could not be definite about this matter and very fairly said that due to the absence of vitreous fluid post mortem to analyse for urea, electrolytes and glucose, which would have settled the matter one way or another, he could do no more than speculate. Professor Pounder's evidence in respect of the absence of signs of severe dehydration post mortem or pre-renal failure confirmed my view that dehydration could not directly be linked to Angela Smith's death. A small amount of urine was found post mortem and while this revealed traces of diamorphine on analysis, the absence of ketones was not suggestive of Angela Smith being severely dehydrated or in pre renal failure. There was no proof of Angela Smith having had an electrolyte imbalance sufficient to have triggered a heart attack.

[20] Ultimately I preferred Professor Pounder's evidence that there were a number of stressors on Angela Smith which may have combined to cause a fatal heart attack. These included the withdrawal of illicit drugs due to her detention, vomiting, lack of fluid and a relatively low food intake. Although empty packets which had contained diamorphine were found in Angela Smith's jeans pocket there was no evidence that Angela Smith had died of a drugs overdose or following the consumption of drugs in her cell. Angela had been a polite, compliant prisoner and never rang the buzzer in her cell at any time to ask for attention and that fact alone was suggestive of her suffering a sudden heart attack or becoming ill to call for help before she died.

[21] More serious than the lack of supply of an adequate amount of fluid was the lack of proper observations and an adequate system of making care plans for at risk prisoners seen by a nurse and ensuring custody staff and nurses worked effectively to keep the duty sergeant informed of changes in a prisoner's condition so that any reassessment of risk could take place.

[22] Many of these issues can be linked back to a failure of custody staff to follow police guidelines by making inadequate observations and mistakes which were made when recording data on the computer system. In Angela Smith's case the fact she had been sick was not noted, it was wrongly noted she had accepted breakfast when in fact she had declined it and some of the observations were attributed to the wrong PCSO which could have compromised any subsequent check nor inquiry. Given the cursory nature of all of PCSO Gallagher's observations she could at best only have focused on the bed area of the cell where Angela Smith was sleeping and since the cell light was not illuminated on any of those occasions there was only low level lighting to assist viewing. Consequently I did not find PCSO Gallagher's evidence credible or reliable that there was no vomit visible in Angela Smith's cell. I am unable to conclude when Angela Smith was sick for the first time in police custody other than to say that it was sometime between 5 42 pm on 25 January and 7 05 am on 26 January. I accept that Nurse Gourlay had to prioritise the patients she had to see on the night of 25 and 26 January and accept placing Angela Smith last on the list after 10-12 male prisoners and a female was a reasonable response

to the information before her. She did appear to have time to see Angela Smith that night but was dissuaded from doing so by PCSO Gallagher who made this suggestion based on her brief observations that Angela Smith appeared to be having a quiet night sleeping.

[23] Despite there being clear written guidance for custody staff to regularly rouse prisoners to ensure they were alive and well, a canteen culture had developed that to disturb a prisoner who might be asleep would be a "breach of their human rights". Needless to say no case law was produced to support such a view. Custody staff may well have had complaints from prisoners at the time about being wakened by cell door hatches being opened to inspect the cell but these intrusions need only be for a few seconds and it would seem that the overriding public interest would be to ensure persons detained in custody are alive and well and fit to be kept in custody pending a court appearance or released or taken to hospital if their fitness for continued detention comes into question.

[24] The delay in Angela Smith being assessed by a nurse may or may not have been significant. It is not possible to reach a concluded view on this point as there was no clear evidence before me when Angela Smith was sick on the night of 25 and 26 January. No one seems to have asked Angela Smith when she had been sick and since she was sleeping when the vomit was first noticed at 7 05 am on 26 January and was left until after 9 am for the mess to be cleared up it would be difficult for a prisoner without a clock or watch to hand to be definite when in the night the vomiting had occurred. It is hardly surprising Angela Smith refused breakfast when a patch of vomit remained in her cell. The duty sergeants and senior police officers who were asked in evidence about the delay in clearing up the cell all said it was unacceptable.

[25] Although drugs were given to Angela Smith after her assessment on the morning of 26 January without being properly prescribed, I do not consider this chapter of the evidence significantly impacted on Angela Smith's death. It seemed clear from the evidence that Angela Smith's condition improved during the course of 26 January. After receiving the initial medication at 9 23 am on 26 January, Angela Smith said she felt better when spoken to at 12 20 pm when she was given a second dihydrocodeine tablet. Although she refused lunch, having refused breakfast she did accept tea and ate some of it at some stage probably between 5 09 pm and 5 38 pm when she was given a third dihydrocodeine tablet.

[26] Ideally Angela Smith should have been re-assessed to check the medication prescribed to her was having the desired effect. It appeared that prisoners were either assessed in the medical room or had brief contact with nurses when given medication. Much of this contact however was taken up with checking it was the correct prisoner being given the correct medication and very little time was left to seek feedback from the prisoner or ascertain whether the condition of the prisoner had improved, remained stable or deteriorated. I understand it is now the practice for nurses in the custody suite to formally review prisoners who have been medically assessed, at 6 hour intervals.

[27] The remains of what was probably the 5 38 pm dihydrocodeine tablet were found in the cell toilet where Angela Smith had been sick that evening and the probable remains of the earlier tablet given at 12 20 pm were found in Angela Smith's stomach contents at post mortem. It cannot be determined with any precision when Angela Smith was sick on the evening of 26 January. I accept the evidence of PCSO Leitch and Nurse Logan that

Angela Smith had not been sick before medication was given at 5 38 pm and since PCSO Montgomery's observation at 6 55 was via the hatch I accept that there was nothing significantly untoward at that time. Certainly Angela Smith made no complaint and there was no evidence that Angela Smith operated her cell buzzer to obtain assistance. By that stage Angela Smith had been shown where the buzzer was near the cell toilet and when Angela Smith was sick she was sick in the toilet, in a beside sick bowl and on the cell floor.

[28] On the first occasion Angela Smith was sick, the previous night this had resulted in her vomiting bile. She had had little to eat in the previous 24 hours and from her general state of health it appeared she was malnourished. By the evening of 26 January apart from a cup of tea, half a chocolate bar and 3 cups of water with her medication Angela Smith had taken on little food or fluids. While Professor Busuttil and Dr. Arango had accepted the vomit found in the cell after Angela Smith's death was of the "coffee ground" variety, there was no pathology to support this by way of stomach lesions albeit this may not always be apparent at post mortem. However once Professor Pounder gave evidence locus photographs were produced and Professor Pounder's view was the colour of the vomit had been due to the recent ingestion of the chocolate bar and was not "coffee ground" vomit.

[29] Despite the poor quality of observations made on Angela Smith while in custody, the delay in having her examined by the nursing staff, irregularities in prescribing drugs to her while in custody, failings in search procedures, inadequate provision of fluids, I am unable to conclude that all those failings in the provision of care for Angela Smith caused her death.

[30] There was evidence given that over 250,000 prisoner receptions have taken been accommodated in the period that St. Leonard's has been in operation-over twenty years. Given the poor health of many of the people taken into custody and the stress on individuals it is inevitable that death may occur. The paradigm case of the prisoner in apparent good health who dies suddenly when in custody and is subsequently found to have a previously unknown health or medical condition cannot be prevented. By comparison, Angela Smith gave information about her drugs problem; she was correctly noted as being at risk and a potentially vulnerable prisoner. Steps taken to assess the nature and extent of her difficulties were delayed but even if observations had been increased and had been of the correct quality I cannot exclude the possibility that around the time of Angela Smith's death on the evening of 26 January observations could properly have been re-set at hourly intervals and consequently the vomiting and sudden death could have taken place between two such observations.

[31] Had Angela Smith been taken to hospital on the morning of 26 January it seems likely that she would have been discharged and returned to custody within a few hours. I was satisfied that the assessment carried out on Angela Smith by Nurse Madden and Nurse Logan was properly carried out and the results concluded Angela Smith was suffering moderate drug withdrawal symptoms. Professor Busuttil felt there would only have been a chance of saving Angela Smith if she had been in high dependency care at a hospital attached to a heart monitor which could have immediately alerted staff to the problem and been able to carry out immediate resuscitation and treatment. This seemed a bit far-fetched but it did highlight the fact that even with better quality regular

observations by nursing staff and oral contact Angela Smith could have died suddenly between such visits.

Did the systems contribute to the death?

[32] Even with the “wisdom of hindsight”, I do not consider that there were reasonable precautions which could have been taken to avoid Angela Smith’s death. As I have highlighted, observations should have been of better quality in terms of the guidance which was in place for custody staff. As Angela Smith was an at-risk prisoner who had suffered drugs withdrawal whilst in custody she ought to have received more nursing contact. The circumstances of death however point to sudden death from a heart attack at some stage after Angela Smith was violently sick. Unless this had occurred at the time of observations there would have been little chance of preventing the heart attack from being a fatal one.

[33] By the end of the inquiry there was agreement among parties that the innovatory scheme to have nurses within the custody suite supported by doctors was a good one and whatever the failings that may have occurred in Angela Smith’s case the presence of nurses on site seemed to be the way forward. A slightly different pilot scheme is being assessed in the Tayside area. Evidence was given by Detective Chief Superintendent Graham that the future may be to have doctor’s surgeries located in major centralized custody suites to tackle the immediate health needs of prisoners many of whom, like Angela Smith when taken into custody are not registered with a GP practice. Further consideration of such structures is beyond the scope of this inquiry.

[34] I was impressed with the quality of the nursing staff; all had at least 10 years nursing experience and most had worked in secure wards or other specialist nursing areas. The contract between Lothian and Borders Police and NHS Lothian called for prescribing nurses but in the event no such nurses were involved in the scheme and efforts made to gain the necessary qualifications were seen as too long and time-consuming and of little relevance to the problems encountered treating prisoners who were under care perhaps for a few hours or days at most. There was evidence that a patient group directive and protocols were now in place to inform nurses what to do with prisoners assessed as experiencing drug withdrawal. This seems an appropriate way of treating such cases.

[35] Nurse Madden had overstepped his position to prescribe drugs to Angela Smith but his approach was later approved by Dr Kaim. While perhaps too much dihydrocodeine was administered in terms of the protocol in use, it was clear that Angela Smith had a tolerance to this drug and there was no question of medication administered by the nursing staff playing a part in her death.

[36] Matters may have had a different outcome if Angela Smith had been assessed by the nursing staff earlier. Nurse Gourlay was dissuaded from seeing Angela Smith during the night of 25 and 26 January by PCSO Gallagher, who had exceeded her authority. The duty sergeants did not appear to pick this up and seemed content with the situation when Angela Smith was seen by the next nursing shift on 26 January and medication prescribed. It is not possible however on the evidence and sudden nature of Angela Smith’s death to be more definite on this point.

[37] While Angela Smith's status as a prisoner remanded for an appearance at court on the Monday morning was regularly considered by successive duty sergeants this assessment went little beyond considering the gravity of the charges which she faced. There seems no doubt that Angela Smith and her co-accused faced a likely appearance on a petition charging them with various drugs trafficking charges in light of the amount and type of drugs recovered together with substantial sums of money and the paraphernalia of dealing. So far as that aspect of the matter is concerned I am satisfied Angela Smith was properly detained. No criticism of the Lord Advocate's Guidelines to Police was made and one can see the public interest in ensuring persons charged by the police with such offences are reported to the authorities as a matter of priority and by detaining accused in custody for the earliest possible court appearance this can be achieved. Also where this approach is taken any supply which may have been ongoing at the premises will be disrupted. Evidence of the type recovered in this case if proved against an individual might well result in a term of imprisonment being imposed on the offender for trafficking in drugs.

[38] The second consideration which must be borne in mind by the duty sergeant is whether a prisoner is fit to be detained. Prisoners may have been injured prior to or while being arrested, some display signs of mental illness, others may be severely intoxicated by drink and/or drugs. From what was seen on CCTV and the evidence given including that from expert witnesses, Angela Smith was fit for custody when presented at the Charge Bar at 2pm on 25 January, she remained fit for custody that evening and was fit to be kept in custody after her assessment by nursing staff on the morning of 26 January. She was also fit to be detained when given her tea and medication at 5 09 and 5 38 pm respectively and gave no sign of not being fit to be detained when spoken to by PCSO Montgomery at 6 55 pm on 26 January. Apart from the nursing forms raised when Angela Smith was examined on the morning of 26 January the duty sergeants had no other information upon which to base this decision and the evidence was that they did not consult the individual prisoner computer records kept for each prisoner by PCSOs. This in turn meant that such records were unhelpful and sometimes inaccurate as staff received little or no feedback about them.

[39] In my view there is a third consideration which has to borne in mind in this context. The evidence of custody staff and police officers was that around 80% of prisoners detained in the custody suite were the subject of an At Risk form. This is not totally surprising given the wide ranging nature of the medical questions posed when accused persons are processed at the Charge Bar. Some prisoners might only be at risk to the extent that they have a treatable medical condition for which they receive a regular prescription; others may be more problematic. Angela Smith's circumstances were all too familiar to custody staff. Aside from dealing with prisoners affected by drink, a large cohort will present with the symptoms of drug problems or addiction. Some of the effects of withdrawal were known to custody staff but their knowledge when tested in court did not extend to all of the main symptoms which can manifest themselves. It is a well-known feature of enforcement action against suspected drugs dealers to arrest them over week-end. The cases can be complicated evidentially and such raids can disrupt the illicit trade if dealing centres are shut down for several days rather than a day or two. This strategy has the knock-on effect that custody suites may have to retain for court over a period of days prisoners who have significant drug problems. Drugs withdrawal becomes

apparent after a day or two. Angela Smith said she had not taken any drugs since 24 January so it could have been no surprise in light of the information she gave police at various times on her arrest when she displayed the symptoms of drugs withdrawal on the morning of 26 January.

[40] The system worked to the extent that Angela Smith was flagged up as an at risk prisoner by virtue of her drug problem. Ultimately she was seen by nursing staff, (albeit late) as envisaged when taken into custody but thereafter successive duty sergeants took no part in monitoring her condition and there was no re-assessment of her risk after arrest. Prisoners are observed on an hourly basis unless the duty sergeant decides observations should be more frequent or the prisoner should be continuously monitored in an observation cell or by a member of staff. On the evidence disclosed there was no need for continuous observation. Special cells are used for those who are prone to suicide or self harm and special measures are taken for murder accused and the like. Angela Smith was polite, compliant and uncomplaining. Had a system been in place to correctly monitor at risk prisoners to see whether the risks might increase or decrease then there would have been a period after Angela Smith's assessment by nursing staff where observations might have been increased. In the event Angela Smith was seen or spoken to on 17 occasions between 9 24 am and 6 55 pm on 26 January. These contacts were fairly brief and the lack of a care plan following the nursing assessment meant staff were not focused on the need to ensure Angela Smith's condition did not deteriorate.

[41] The other factor to consider in this context was the quality of handovers given by all of those who worked in the custody suite. It was recognised as being a high pressure high risk environment with the need for CCTV monitoring to ensure high standards of working and protect staff and prisoners from abuse. In general the handovers by the nursing staff were adequate although not to the level carried out in a hospital setting. I understand improvements are now in place to retain handover notes which were prepared. By contrast neither the sergeants nor custody staff had any formalised handover system. It was difficult to ascertain what if anything was said about Angela Smith after her initial reception. I appreciate there may well have been difficult, demanding and vocal prisoners who would require to be highlighted to the next shift. It seemed however that Angela Smith's compliance, politeness and lack of complaints may have militated against her notwithstanding that she was an at-risk prisoner who had required to be seen by nursing staff.

[42] Evidence was given that prisoners who are assessed and found to be suffering from drugs withdrawal will be re-assessed to ascertain whether treatment is working or not. This seems a useful improvement because as Professor Gourney pointed out the nursing assessment did not conclude with a nursing plan being put in place. While the forms completed by nursing staff were fairly comprehensive perhaps due to the transient nature of the patient group and the relatively short period prisoners were in their care the nurses did not seem to think in terms of nursing plans other than in the prescribing of medication at regular intervals. Had such plans been in place there would then have been a need for better observations by PCSOs and better liaison with the duty sergeant to monitor the condition of an at risk prisoner and be alert to any deterioration.

[43] My impression was that nursing staff and custody staff got on well with each other. Custody staff were grateful to be relieved of a problem area and pleased to have reduced

the number of visits to hospital with prisoners. However nursing staff were not free to check on prisoners without a custody officer present. Although working as a team nursing staff had their own office and it might improve working if, apart from when in the medical room assessing prisoners they were in a communal working area with custody staff. There seemed scope for more joint training.

[44] In IHB Carmichael's book (supra) at para 5-76 page 174 commenting on section 6 (1) (d) of the 1976 Act which deal with the defects, if any, in any system of working which contributed to the death, the learned author states:-

"The phrase "system of working" must be understood as including ... (deaths in legal custody and the like) any system or lack of system of working such as supervision where necessary, or routine in any custodial institution, where such has contributed positively to the death".

[45] After hearing the evidence of PCSOs and duty sergeants I was left with an impression of complacency. Prisoners being sick and/or experiencing drug withdrawal are no doubt daily features of the work they have to deal with. While rounds of observations generally were made timeously in terms of the guidelines staff did not seem to realise the significance of what they were doing and why they were doing it. Where a prisoner dies in custody there requires to be a public inquiry. Custody staff are required to give an explanation of the surrounding circumstances and records including CCTV will be checked to ascertain if the death could have been avoided.

[46] Whether a prisoner is disruptive and difficult or in Angela Smith's case quiet and compliant, the task of custody staff is the same to ensure the welfare of the prisoner until he or she is released or transferred elsewhere. Since liberty has been removed from the individual and security is in place to prevent escape then the welfare of the prisoner is paramount. Incarceration in a custody suite will be a stressor for most prisoners quite apart from any special risk factors that are identified in any particular case.

[47] Ultimately however I do not consider the evidence entitles me to make any finding in relation to section 6 (1) (d) of the 1976 Act. As Dr. Grieve pointed out in his evidence if Angela Smith had not abused drugs "we would not be here" [at a Fatal Accident Inquiry]. Angela Smith's years of abusing drugs had resulted in damage to her heart which resulted in her sudden and unexpected death. Despite the inadequacies of the system and its operation, I cannot conclude the system contributed to her death. Angela Smith was susceptible to a sudden heart attack. There was no evidence that she was aware of this problem and unless a heart attack had occurred at a time where help was at hand and immediate resuscitation given, death would have been likely.

Other facts which are relevant to the circumstances of death

[48] In I H B Carmichael's book (supra) at para 11-07 at page 413 he quotes with approval Sheriff Kearney's remarks in the Mildred Allan FAI, Glasgow 14 November 1985 dealing with the purposes of FAI procedure:-

"The provisions of section 6 (1) (e) [of the 1976 Act] are still wider and, in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the

course of the inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.”

This passage has been quoted favourably in a number of Inquiries since then although the court must be wary of making general findings and recommendations arising from the examination of one set of circumstances-see Carmichael paras 11-08, 11-46 and 8-39 and indeed Chapters 8 and 11 of the book generally.

[49] This inquiry highlighted the poor physical shape that many prisoners may be in when taken into custody with a drug problem. The CCTV evidence showed the quality of cell observations was poor, and the noting of those observations formulaic and ultimately unhelpful in trying to ascertain when and how the death of a prisoner occurred. At PCSO, PCSO Supervisor, Duty Sergeant levels there was widespread non-compliance with police guidelines. Pressure of work and the supposed human rights of sleeping prisoners were advanced as reasons why observations were brief and supervision ineffective. Bad observation practice was widespread due to poor supervision. CCTV monitors, apart from those monitoring the observation cells gave poor reception and did not seem to be consulted by supervisory staff to check custody staff carried out their duties properly. The PCSO Supervisor sat at his desk with his back to the monitors. Reliance “on the professional standards” of custody staff and supervisors was misplaced.

[50] In the months after Angela Smith’s death Chief Inspector Beveridge undertook a review which improved matters but custody staff (with the notable exception of PCSO Montgomery) gave evidence to the effect that they had not changed their practices when observing prisoners. The police view was that existing guidance was sufficient and extra training, team building was all that was required to improve matters.

[51] Although I do not find established that system failures contributed to Angela Smith’s death, I consider the evidence which emerged in this long inquiry should be examined by the police service and NHS to ensure at-risk prisoners are flagged up with all relevant information known about the risk. Where a nursing assessment is indicated this should be carried out promptly and the results assessed by the duty sergeant to determine whether the risk level has increased or not. The frequency of observations may need to be increased and the quality of these observations should be such that they are of assistance to the nursing staff in determining whether a re-assessment is required.

[52] Nurses and doctors operating from custody suites are welcome steps forward but consideration should be given to joint training and co-location of staff to improve the flow of information on the condition of at-risk prisoners. It was noted that basic terms such as “observation” and “controlled drugs” have significantly different meanings in police and nursing circles.

[53] It is an onerous task to ensure the welfare of large numbers of prisoners where turnover of inmates is continuous. Prisoners in a custody suite are under the protection of the law and justice demands their prompt and safe transfer to a court or elsewhere in the system as appropriate. Many prisoners’ health issues may have to be addressed during this time, most of which will not require hospitalisation. Numerous observations have to be carried out to ensure the welfare of prisoners. Most of these observations are routine and mundane but in each case it needs to be ascertained if the prisoner is alive and well or further action may need to be taken.

[54] The present system of patrolling corridors and entering details later for a number of prisoners on a computer can lead to bland and unhelpful entries or the omission of important details where interrupted or under pressure. It is to be hoped that modern technology can be used in this setting in the future to enable custody staff to properly, timeously and quickly record their observations in such a way that the information is of value to colleagues including if need be nursing staff so that a prisoner can be re-assessed regarding at-risk status. At present the focus seems to be on ensuring various observations are made at the appropriate time and a log kept. It is a matter of concern when these entries are at variance with CCTV footage and of little use in determining when and why a prisoner died in custody.

Other issues raised at the Inquiry

[55] A considerable number of other issues were raised at the Inquiry which, in the event, I did not consider were related to Angela Smith's death and do not fall to be dealt with in my findings-in-fact or in my Determination. It is appropriate however to mention them in this note and my reasons for not founding upon them.

[56] I have already discussed the flaws in search procedures. I am satisfied Angela Smith's clothes were properly searched initially by Constable Said before she put them on after being found in bed by police officers enforcing the search warrant. I am satisfied that when Angela Smith was strip searched by Constables Said and Mitchell at her house this was carried out thoroughly and nothing was missed. It appears however that Angela Smith put on a brassiere, fleece top, coat boots and jewelry prior to being transported to St. Leonard's. No evidence was forthcoming about these items being searched prior to being worn. The search at the Charge Bar was not totally thorough. Constable McDonald was corroborating the search but was not well-positioned to see everything and was distracted on occasions. Search at the Charge Bar seems a more formal process designed to account for a prisoner's personal effects and check nothing has been missed from what requires to be a thorough search when taking someone into custody. Angela Smith's socks were not searched and she appeared to retain a tissue that she removed from her fleece top and put on the Charge Bar prior to retrieving it. This did not seem to be a contrived action by Angela Smith and it looked unlikely the tissue could have contained the drugs wrappers found in her jeans after death. Whether Angela Smith smuggled drugs into St. Leonard's in her clothing or discovered them in her cell or indeed smuggled them in internally there was no evidence of ingesting illicit drugs while in custody or snorting them prior to death. The finding of drugs wrappings on Angela Smith's body must be an embarrassment to the police and the officers involved in searching Angela Smith but this does not appear to have been a factor in her death.

[57] Criticism was made about deficiencies in the transfer of information relating to Angela Smith among police, custody and nursing staff during her time in custody. There is no doubt that at different times Angela Smith gave slightly different versions about her drug intake when initially detained, at the Charge Bar and at police interview. The extent of heroin addiction was underplayed when asked questions at the Charge Bar. This forum, being semi-public is not ideal when seeking private information from individuals. When Angela Smith was seen by nursing staff the following day she gave similar

information about the extent of her heroin habit as she had given when spoken to directly by police detention and interviewing officers. Apart from flagging up on a whiteboard in the sergeant's office that Angela Smith was an at-risk person who required to be seen by a nurse and subsequently that she required regular medication, there was no mention of her name at staff handovers presumably on the basis that she was a quiet and compliant prisoner. As an at-risk prisoner she should have had her risk status under review and to that extent ought to have been mentioned to the sergeant taking over duties.

[58] A research exercise was ongoing at that time and Angela Smith should have been subjected to a mandatory drug test. It would appear after it was realised this had been omitted it was felt too late to carry it out. This was unfortunate but it is questionable if it would have made any difference to the treatment she received or the outcome.

[59] As I have indicated there were flaws in the unauthorised prescribing of medication to Angela Smith by nurses in the custody suite but I do not think this had an impact on her death. There seems no need for custody suite nurses to be prescribing nurses now that a patient group directive is in place providing a protocol for dealing with prisoners exhibiting drug withdrawal symptoms. I am satisfied that systems are in place to avoid this and ensure Forensic Medical Officers approve medication and satisfy themselves about the treatment given.

[60] I was impressed by Professor Gournay's evidence and am satisfied all at-risk prisoners seen by nursing staff require to be the subject of a care plan while in custody with steps taken to ensure information is conveyed with the prisoner on transfer elsewhere or given to the individual on release. It is vital that where a prisoner is assessed by nursing staff and found to be a cause for concern this condition is monitored either by giving specific directions to custody staff as to observations and/or the nurses are free to follow up an re-assess as appropriate. The innovative scheme with nurses located in the custody suite which was in force at the time of Angela Smith's death continues to operate and its success depends up a free flow of information, co-location and team working to ensure the well-being of prisoners. This provides savings in police time taking prisoners to hospital except for those instances where a prisoner's fitness to be detained is called into question and requires to be treated elsewhere.

[61] Angela Smith's fluid intake was extremely low when in custody. She was not seen to eat or drink when being dealt with by police nor was she offered any fluids when in custody other than at meal times and when given medication. Custody staff said that water was always available on request and the occasional extra cup of tea might be provided. No differentiation was made on the custody record from the acceptance of food or water. Some consideration will require to be given about this matter to ensure prisoners are offered water more frequently particularly when at-risk or likely to be dehydrated by repeated sickness and/ or diarrhoea.

[62] I do not consider Angela Smith's condition was seen to be such as to require her transfer to hospital for treatment. She had been assessed as having symptoms of moderate drug withdrawal and appeared to respond to medication and did not complain further. If she had been taken to hospital it is likely she would have been returned shortly afterwards from Accident and Emergency and it is highly unlikely she would have remained in

hospital being monitored in such a way that any heart attack would have been immediately detected and resuscitation undertaken straight away.

[63] I appreciate Angela Smith's family were particularly concerned about the attendance outside her cell on the morning of 26 January at 3.19 by PCSO Gallagher and 3 other male PCSOs, one of whom who looked into the cell spy hole before PCSO Gallagher contrary to police rules. PCSO Gallagher was unable to explain this incident and I upheld an objection to hearing evidence from the male officers since I considered the matter too remote from the time and circumstances of Angela Smith's death. PCSO Gallagher had briefly checked Angela Smith's cell about 15 minutes beforehand and shortly prior to that a rowdy female prisoner had been placed in a nearby cell as she was too unruly to be processed at the charge bar. The only other possibility was that the officers had gloves on to clean up a cell but after briefly looking in the spy hole they left and observations were resumed about 15 minutes later until PCSO Gallagher concluded her shift. This matter if of any significance is outwith the remit of this inquiry and if concern remains the family will require to pursue the matter with the police if they wish to secure any explanation of this apparent departure from custody guidelines.

[64] Criticisms were leveled at the detail and management of the nursing contract within the custody suite. While mistakes occurred I do not consider the lack of prescribing nurses, mistakes in prescribing and the administration of medicines to Angela Smith without proper authority were factors in her death. I am grateful to the family of Angela Smith while being concerned about these aspects of the operation of the scheme they were magnanimous in their appreciation that a scheme such as in place in St Leonard's can only be an improvement for the health and welfare of those detained in custody. It has been recognised since Angela Smith's death that a full nursing assessment should be followed up by formal re-assessments. While Dr. Kaim was criticised for not seeing Angela Smith when he attended at the custody suite at midday on 26 January he was fully briefed on Angela Smith's case, saw the relevant paperwork and approved what had been done by way of administering medication.

[65] Another criticism related to the lack of effective overall management of the teams responsible for the care and welfare of prisoners in St. Leonard's. It is clear that there seems to have been an abdication of responsibility which appears to have occurred from 2006 with the introduction of PCSOs. The officers were given additional responsibilities to those held previously by turnkeys and as a result often the only police officer present in the custody suite would be the duty sergeant. That officer in effect has the authority under statute and no doubt force instructions to determine which persons detained and presented at the Charge Bar should be remanded for appearance at court or held for possible transfer to a mental hospital and the like. Statutory requirements in this context are not as explicit as those under the Police and Criminal Evidence Act 1984 which applies in England and Wales. While Chief Inspector Beveridge gave evidence about the improvements made since Angela Smith's death these were against a backdrop of the same guidance regime remaining in place which had been in force at the time of Angela Smith's death although elements of it had been ignored for various reasons. There did appear to have been a complacency amongst staff about the quality of observations, the personal involvement of the sergeant in seeing and regularly assessing each prisoner. If these important considerations are emphasised by better training and team working and

co-location of staff carried out to fully incorporate nurses into the arrangements to ensure the care and welfare of prisoners there is a much improved chance of a better outcome with at risk prisoners who have a greater potential for suddenly and unexpectedly presenting staff with an emergency.

[66] I accept that steps have been taken to reduce the pressure and interruptions on duty sergeants that seemed to divert them from their main task at the time of Angela Smith's death. It is to be hoped that greater engagement by duty sergeants with custody staff and supervision of their records and observation practices will result in improved performance and less reliance on the assumption staff will operate "in a professional manner at all times." CCTV equipment is of great assistance and an important regulator of behaviour in the custody suite. However observations and maintenance of records are crucial and remain outwith the scope of CCTV. Deficiencies in observations and recording, as we have seen, cast doubts in areas where there should be none as to the status and fitness of prisoners held in lawful custody.

Conclusions

[67] I am grateful to parties for their assistance in this inquiry. My only criticisms are that despite a number of preliminary hearings we were not able to focus all of the issues in advance of hearing evidence. In large part this was due to the late arrival of certain expert reports and the need for a response to some of the issues raised. While I accepted that a joint minute of agreement was a competent way of adducing evidence which parties were agreed upon I was concerned that the minute was not produced until the last witnesses were called. Unlike criminal proceedings I do not consider the sheriff at a fatal accident inquiry should be fettered by material contained in a joint minute. In the event I have accepted the terms of the joint minute at face value but it would have been more helpful if it had been presented at the outset or during the early stages of the evidence along with the locus photographs.

[68] Finally it remains for me to express my sympathy to the family for the loss of their daughter and sister. Hearing of a particular case brings home all the more the devastating effects a drug habit can have on an individual and the family. Members of the family were in attendance at all hearings and in addition Angela Smith's sister and brother visited the custody suite when the Inquiry attended there. I appreciate the concentration, stamina and quiet dignity which the family displayed during this lengthy inquiry. I trust that lessons will be learned from this sad case to ensure at-risk prisoners taken into custody are appropriately monitored.

