

SHERIFFDOM OF GRAMPIAN, HIGHLAND and ISLANDS at INVERNESS

Fatal Accident Inquiry

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976

Case No. B79/12

DETERMINATION

by

SHERIFF MARGARET M. NEILSON

**following an Inquiry at
Inverness Sheriff Court
into the circumstances of the death of**

GERARD McNALLY

INVERNESS, 25th May 2012

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Gerard McNally, Determines in terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976 as follows:

In terms of Section 6(1)(a)

The late Gerard McNally (date of birth 4th August 1962) died at Raigmore Hospital in Inverness at 11:56am on 13th August 2010.

In terms of Section 6(1)(b)

Mr McNally died from the effects of Phosphine Toxicity having ingested a quantity of Phostoxin.

In terms of Section 6(1)(c)

There were no reasonable precautions which might have prevented Mr McNally's death.

In terms of Section 6(1)(d)

There were no defects in any system of working which contributed to the death of Mr McNally.

In terms of Section 6(1)(e)

There are no other facts which are relevant to the circumstances of the death of Mr McNally.

Sheriff

Findings in fact

(1) By Thursday, 12th August 2010, police officers of Northern Constabulary had obtained a warrant from a sheriff entitling them to search the property occupied by Mr Gerard McNally ("the deceased"), at 3 The Riggs, Fort Augustus, for certain items of property believed to be in his home as part of their enquiries into serious allegations made against him.

(2) Members of the deceased's family had already been interviewed by police officers. The deceased was aware of the allegations and the investigations that were taking place.

(3) The deceased was aware that he was likely to be detained by police officers as part of these investigations.

(4) The deceased and his wife had expected police officers to attend at their home to detain him on Thursday, 12th August 2010, and were surprised that they had not done so.

(5) On Friday, 13th August 2010, following a briefing at 08.00 at Fort Augustus Police Station conducted by Detective Constable Muriel Fuller, police officers and scenes of crime officers attended at the deceased's home around 08.20.

(6) The briefing had been detailed. It considered, amongst other things, potential risk to all persons involved, including the deceased. It was known that there were dogs within the property and that one of them at least could be aggressive. There was no information or intelligence which suggested that the deceased might be a suicide risk.

(7) When the police officers knocked on the door, the deceased was still in bed. He got up, looked through the spy hole, saw the police officers, shouted to his wife that it was the police and that she should get up and then went to the bedroom and put on jogging bottoms and a tee shirt before answering the door. The deceased answered the door a few minutes after the initial knock by police officers.

(8) After the deceased had opened the door, police officers asked him to secure the three dogs which were within the house. The deceased left the doorway (which remained slightly open as a police officer had placed her foot in the door to prevent it shutting), went out of sight of the police officers briefly and secured the dogs within his bedroom. He then returned to the door.

(9) Police officers entered the house and went to the livingroom with the deceased and his wife. The deceased sat down on a chair and his wife sat on the arm of the chair. The warrant was passed to the deceased but as he could not read and write, it was read to him by his wife. The deceased appeared calm and was co-operative.

(10) The deceased was detained by police at 08.27. He was not handcuffed within the house. He asked if he could have a cup of tea but this was refused because of time constraints following detention. He asked for a cigarette and some water. He smoked the cigarette in the livingroom. He went into the kitchen, to the kitchen sink and took a cup of water. Detective Constable Fuller followed the deceased into the kitchen, saw him going straight to the sink, heard the water run and saw him drinking a cup of water. As she was smaller than the deceased and was standing behind him, she could not see in detail what he was doing but had no reason to believe he was doing anything other than taking a drink of water.

(11) The deceased went to the bedroom to get fully dressed. He was accompanied by Detective Sergeant Edward Ross who searched his clothes. He found only tobacco and a lighter.

(12) The deceased asked not to be handcuffed before he left the house as he did not want neighbours to see him in handcuffs. He also said he would not be running away. Police officers agreed not to apply handcuffs until he was in the police vehicle.

(13) As the deceased was leaving with the police officers he said to his wife something along the lines that she would not see him again. His wife did not understand what he meant at the time.

(14) At some point on the morning of Friday, 13th August 2010 prior to leaving his home with the police officers the deceased ingested a quantity of Phostoxin, probably one tablet.

(15) Detective Constable Fuller and Detective Sergeant Ross accompanied the deceased into the unmarked police vehicle. Detective Constable Fuller was driving and Detective Sergeant Ross sat in the back seat beside the deceased, who was sitting in the nearside rear passenger seat. They left Fort Augustus to travel to Burnett Road Police Station, Inverness. Handcuffs were applied to the deceased once he was in the police vehicle.

(16) After setting off on the journey the police officers chatted to the deceased about various topics, including his inability to read and write and his education. They did not discuss the allegations made against him and specifically told him that they would not be discussing them. Initially the deceased seemed relaxed and happy to chat with the officers.

(17) After a few minutes the deceased started slurring his words. He looked sweaty and felt cold to the touch. He stopped speaking. He signalled that he needed to be sick.

(18) The window on the police vehicle beside the deceased was wound down. The deceased vomited through the open window.

(19) Detective Constable Fuller stopped the vehicle twice on the journey, once just North of Invermoriston in a driveway on the side of the A82, the main route between Fort Augustus and Inverness, to enable the deceased to vomit and once at the public toilets in Drumnadrochit to let the deceased defecate.

(20) The police officers asked the deceased if he had a medical condition and needed medication but he said he did not. They also asked him if he had taken any substance which might have caused him to be ill but again he said he had not.

(21) The police officers assumed that the deceased was car sick, because of the winding road between Fort Augustus and Inverness and because of the stressful situation he was in. It is not uncommon for detained persons in this situation to feel ill.

(22) As the vehicle approached Inverness, the deceased again complained of needing to use a toilet. He was told that they were then within a minute of reaching Burnett Road Police Station.

(23) Immediately on reaching the cell block area in Burnett Road Police Station, at around 09.39, police officers showed the deceased to the nearest toilet and left him in private to use it. Police officers regularly checked that he was not in any difficulty.

(24) Meantime Police Sergeant Andrew Blakey and Police Constable Emma Holgate had been tasked to go to the deceased's home to check for any medication. They were given an angina spray and an inhaler by the deceased's wife. The officers were told that the deceased had not been using these regularly in the recent past.

(25) Police Constable Anthony MacDonald, who was the acting custody Sergeant, was briefed by Detective Constable Fuller. He was concerned about the deceased's health and whether he could be interviewed in his condition. Immediately the deceased arrived he started making arrangements for a police surgeon to attend at the cell block to examine him and for an appropriate adult to be present.

(26) After a short time in the toilet the deceased collapsed. Police officers immediately went to his aid and put him in the recovery position. He was responsive but not coherent. He seemed to recover to an extent. He got up and went back to the toilet. Police officers called 999 at 09.53.

(27) An ambulance with a paramedic (Mr Donald MacDonald) and a technician (Mr David Rose) arrived at the cell block area at 09.58. Police officers had been tasked to await the arrival of the ambulance and were ready to open the gates so it could access the area as quickly as possible.

(28) Mr MacDonald was quickly briefed by police officers and went to tend to the deceased. He noticed a bluish grey powdery residue on the deceased's mouth and lips and became concerned that he might have taken medication or some other substance which had caused him to vomit.

(29) The deceased was still able to talk and move at this time and managed to get himself onto the paramedic's wheeled stretcher with some assistance.

(30) The deceased was asked by the paramedic, Mr MacDonald, both in the cell area and in the ambulance, in the presence of Detective Sergeant Ross, whether he had taken any substance. He consistently denied taking anything. Detective Sergeant Ross left the ambulance for a short time telling the deceased that he should tell the

paramedic if he had taken anything, that the police were more concerned with his health than their inquiries at that stage and that he should co-operate with the paramedic and tell him if he had taken anything, even if he did not wish to say so in front of a police officer.

(31) Despite being left on his own with the paramedic and being urged by the police officer to speak to the paramedic, the deceased continued to deny that he had taken anything.

(32) The ambulance left Burnett Road Police Station for Raigmore Hospital, Inverness at around 10.12. While in the ambulance, the deceased was gravely ill. His temperature was extremely low, measured at 32.8°C. His blood pressure was extremely low, 81/52. His pulse was very high, 110 beats per minute. His blood sugar was high, 14.3. He was cyanosed (blue) and cold to the touch. Mr MacDonald formed the view that he had taken something which had caused him to be ill.

(33) In the ambulance, on the way to Raigmore Hospital Accident and Emergency Department, Inverness, the paramedic asked the deceased on at least four or five occasions whether he had taken anything. He persistently denied taking anything.

(34) Following his arrival at the Accident and Emergency Department at Raigmore Hospital, at around 10.26 the deceased was asked by Dr Noelle Murphy, Consultant in Accident and Emergency medicine, whether he had taken anything. He said for the first time, in the presence of the paramedic, that he had taken a tablet of mole poison.

(35) When it had become apparent that the deceased might have ingested something which caused him to be ill, Police Sergeant Blakey was tasked to go back to his house to look for poison. With the help of the deceased's wife, a partially used container of Phostoxin, (a mole killer), was found on top of one of the kitchen cupboards beside some cereal packets. In addition, a container of ant killer was found on the hall table.

(36) Police Sergeant Blakey returned to Fort Augustus police station which was very close to the deceased's home. He relayed the information about the contents of the container that had been found, namely Phostoxin tablets, back to the doctors at Raigmore Hospital. He was initially asked to open the container to see what was in it

but after discussion with Police Constable Deborah Doherty refused to do so. They shook the container and came to the view that it was not full but still contained some tablets.

(37) At Raigmore Hospital the deceased was transferred to the resuscitation room where a number of medics worked on him.

(38) The deceased sustained a cardiac arrest. He was successfully resuscitated but quickly arrested again. On this occasion he was unresponsive to all interventions. Resuscitation attempts ceased at 11.56.

(39) His life was pronounced extinct by doctors at Raigmore Hospital at 11.56 hours on 13th August 2010 while in police custody.

(40) Phostoxin is a substance which is subject to the Poisons Act 1972. When purchased, it must be signed for. It should be used only by trained operators, such as farmers, crofters and pest controllers. A fraction of one tablet is sufficient to kill an average sized person if ingested. A container should be used completely once open or the remainder of the contents sent to be safely destroyed. A container should not be stored once opened. Phostoxin tablets contain Aluminium Phosphide which reacts to air and liquid to produce Phosphine gas which is highly toxic and extremely flammable. If ingested it affects almost every human organ.

(41) Once it was known what substance the deceased had probably ingested, police officers made immediate contact with the manufacturers and suppliers of Phostoxin in the UK, Rentokil.

(42) Once contacted Rentokil sent two operatives to Inverness, one travelling from Horsham, West Sussex via Gatwick Airport to Inverness Airport and another travelling from Edinburgh to Inverness in a vehicle containing the necessary testing and decontamination equipment. Both arrived in Inverness on the evening of Monday 16th August.

(43) On the morning of Tuesday 17th August and the following two days, following a detailed briefing, the two Rentokil operatives took appropriate steps to test clothing belonging to the deceased and accompanying police officers, the clinical waste from Raigmore hospital, the cell block area in Burnett Road Police Station, the public toilets in Drumnadrochit and the police vehicle for traces of Phosphine.

(44) The clinical waste, which had been sealed in a plastic bag, gave a positive reading for Phosphine gas. Although the items of clothing gave a negative reading, it was felt that this was because they had been stored in paper bags rather than plastic bags and that the gas had probably dispersed by the time they were tested. It was felt necessary for these items of clothing to be destroyed as a safety precaution. Appropriate steps were taken to decontaminate the police vehicle and other locations where contamination was present. The Rentokil operatives also safely disposed of the remaining tablets and made safe the Phostoxin container. They wore full chemical radiological (“CR1”) protective suits for this purpose. CR1 suits have several different layers and are known to protect wearers from chemical, nuclear and radiological agents for at least a few hours.

(45) It was decided after consultation with pathologists that, for reasons of safety, it would be necessary to carry out the post mortem in the open air rather than in the mortuary at Raigmore Hospital, Inverness. Full chemical, biological, radiological and nuclear (“CBRN”) precautions were put in place. Arrangements were made for the post mortem to take place at the police firing range in Daviot Quarry, near Inverness.

(46) There is only one pathologist in Scotland trained to perform such post mortems, Dr Ralph Bouhaidar based at Edinburgh University. He was instructed to carry out the post mortem. He did so wearing a full CR1 protective suit on 20th August 2010.

(47) During the post mortem, samples of tissue and blood were taken for toxicological analysis. It was understood that only one person in Scotland, Dr Robert Anderson at Glasgow University, had the training and equipment to be able to test with absolute certainty for the presence of Phosphine.

(48) A police officer from Northern Constabulary travelled to Glasgow with the samples and delivered them to Dr Anderson. After some time it became apparent that the equipment that was to be used to determine whether Phosphine was present or not, was not operational and, despite efforts being made, it could not be made operational. Police officers from Northern Constabulary continued to check with Dr Anderson on approximately a monthly basis until around July 2011 when, they were instructed by the district procurator fiscal not to pursue this line of inquiry any further.

NOTE

Introduction

[1] This Inquiry was held in terms of Section 1 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the Act”) in respect that the deceased, Mr Gerard McNally, died while in the custody of the police. This is therefore a mandatory Inquiry in terms of Section 1(1)(a)(ii) of the said Act.

[2] Section 6(1) of the Act requires the Sheriff to make a Determination setting out the following circumstances of the death so far as they have been established to his or her satisfaction:

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

[3] The only method of establishing those circumstances is by the assessment of the evidence led by the procurator fiscal and any other interested party represented at and participating in the Inquiry. It has often been said that a Fatal Accident Inquiry is concerned with fact finding and not fault finding. The purpose of the Inquiry is not to attach fault to any person but to inquire into all the circumstances of the accident and the death in order to discover the truth, identify any reasonable precautions which

might have been taken and ascertain if any lessons can be learnt which might serve to prevent the reoccurrence of any similar accident. The word ‘accident’ is not defined in the Act but is generally considered as meaning an unfortunate incident which happens unexpectedly and unintentionally, typically resulting in damage or injury.

[4] At this Inquiry, parties were ably represented as follows:

The Crown: Ms Heather Swan, Procurator Fiscal Depute;

Northern Constabulary: Mr Kirk Tudhope, Solicitor.

I am grateful to both of them for their conduct of the Inquiry and their careful submissions.

[5] The following witnesses gave evidence to the Inquiry, some by giving oral evidence in person and others by Affidavit evidence which was read into the record:

1. Alice Alwyn McNally, step-daughter of the deceased;
2. Amy Jane McNally, step-daughter of the deceased;
3. Police Constable Deborah Doherty, Northern Constabulary;
4. Police Sergeant Andrew Russell Blakey, Northern Constabulary;
5. Detective Sergeant Edward Robert Charles Ross, Northern Constabulary;
6. Detective Constable (Acting Sergeant) Muriel Fuller, Northern Constabulary;
7. Police Constable (Acting Sergeant) Anthony Richard MacDonald, Northern Constabulary;
8. Donald Ian MacDonald, Paramedic, Scottish Ambulance Service;
9. Police Constable Aros Iain Matheson, Northern Constabulary;
10. Detective Sergeant Donald MacPhail, Northern Constabulary;
11. Police Constable Donald Mowat, Northern Constabulary;
12. Police Constable Emma Holgate, Northern Constabulary (by Affidavit);
13. Pamela Elizabeth Wilson, Force Support Officer, Northern Constabulary (by Affidavit);
14. Jodi Busby, Force Support Officer, Northern Constabulary (by Affidavit);
15. Michael William Smith, Custody Officer, Northern Constabulary (by Affidavit);

16. Police Sergeant Ewan Roderick Webster Henderson, Northern Constabulary (by Affidavit);
17. David James Rose, Ambulance Technician, Scottish Ambulance Service (by Affidavit);
18. Dr. Ian Gerald Skipsey, Consultant Anaesthetist, Raigmore Hospital, Inverness (by Affidavit);
19. Dr. Noelle Mary Murphy, Consultant Accident and Emergency Medicine, Raigmore Hospital, Inverness (by Affidavit);
20. Detective Constable Eoin Stuart Coull, Northern Constabulary (by Affidavit);
21. Detective Constable Alicen Winston, Northern Constabulary (by Affidavit);
22. Detective Constable Paul Douglas MacLeod, Northern Constabulary (by affidavit);
23. Detective Constable Roy Reid, Northern Constabulary (by Affidavit);
24. Detective Constable Jennifer Anne Martin, Northern Constabulary (by Affidavit);
25. Detective Sergeant Richard Andrew Ross, Northern Constabulary (by Affidavit);
26. Colin Cameron Murison, Field Biologist, Rentokil Pest Control (by Affidavit);
27. Andrew Leaf, Global Fumigation Manager, Rentokil Pest Control (by Affidavit);
28. Robert Fraser Mackay, Shop Supervisor, Harbro Limited, Inverness (by Affidavit);
29. Dr. Ralph Bouhaidar, Consultant Forensic Pathologist, Edinburgh University.

[6] The deceased's wife, Mrs Angela McNally, was too ill to attend court and give evidence in person. A Joint Minute of Agreement was lodged which stated that the witness statements of Angela McNally, dated 13th, 14th and 16th August 2010 made to various officers of Northern Constabulary were accurate records of the details provided by her. The three witness statements were read into the record.

Witnesses

[7] I heard a considerable amount of oral evidence and had before me the affidavits sworn by other witnesses. I found all of the witnesses who gave oral evidence to be credible and generally reliable. They were clearly trying to assist the court as best they could. A number of the police officers gave the impression of still being shocked and upset by the sudden turn of events on the day in question. Slight discrepancies arose in the evidence of the different witnesses when describing the events but this was normal given the passage of time and also because events happened extremely quickly and suddenly, particularly in the cell block area. Generally the evidence of all witnesses was consistent with that of other witnesses in relation to the material facts in the case. There was a discrepancy between the timings from Burnett Road Police Station and the ambulance logging system. I understood from Mr MacDonald that the ambulance system was probably a few minutes out. I have therefore used the timing from the police system rather than the ambulance system where there were discrepancies between timings. The discrepancies relate only to the actual time of day and there is no dispute, for example, as to how long the ambulance took to get to Burnett Road Police Station once called or to Raigmore Hospital once it left. I do not consider these minor discrepancies to be at all significant or have any relevance in relation to Mr McNally's death.

Cause of death

[8] It was apparent from the evidence I heard throughout the inquiry that the substance ingested by Mr McNally was extremely toxic. Only one pathologist in Scotland is trained to carry out CBRN post mortems. He was instructed to do so and, after discussions amongst the various authorities involved, it was decided that the post mortem should take place outside in a quarry in case Phosphine gas was released from the remains during the post mortem which would cause a risk to those present. Phosphine gas is both extremely toxic and highly flammable. The police, on the instructions of the procurator fiscal, made every effort to have the samples taken from the deceased's remains analysed for toxicology. It was not the fault of the police, or indeed the procurator fiscal, that this analysis never took place. I heard clear evidence from the Consultant Pathologist that this was only the second case of Phosphine

ingestion that he had ever come across in his career and he did not think any other pathologist in the country would have come across any. It is undoubtedly an extremely rare occurrence. Notwithstanding the lack of toxicology results, it was clear from Dr Bouhaidar's evidence that the probable cause of death was Phosphine toxicity. He indicated that had he received toxicology results he would have been able to give that opinion on the basis that it was beyond reasonable doubt but, because of the lack of lab results, he would only give that opinion on the balance of probabilities. The balance of probabilities is of course the standard of proof used in inquiries such as this but not in criminal prosecutions. Taking the pathologist's evidence together with the other evidence before me, it is clear that the primary cause of death is Phosphine Toxicity following the ingestion of at least one Phostoxin tablet by the deceased.

Phostoxin

[9] Clear instructions come with the poison that it is only to be sold to registered users. These include crofters, game keepers and pest controllers. The only supplier in Inverness, Harbro Ltd, checked their records back to 2005 and it was clear from their register that they had not sold the poison to the deceased. They could not completely exclude the possibility that it might have been sold to him had he been working for an estate and had signed under the estate name. The deceased's wife thought he may have had it from when they ran caravan parks some years previously or may have been given it by the landlord of their previous address (Police Constable Aros Mathieson). He gave evidence and, while he accepted that there was a mole problem when he had lived at that address prior to the deceased and his wife moving in, denied that he had given the Phostoxin to Mr McNally. It is not, therefore, clear where he had got it from. What is clear from a number of witnesses, (the Rentokil operatives, the Harbro shop supervisor and Police Constable Mathieson) is that the container found in the deceased's home was an old style one which has not been in retail or commercial use for some years.

[10] The deceased could not read or write but I was satisfied that he knew what the poison was for and had used it previously (for its intended purpose of killing moles), from the evidence of both his wife and his step-daughter Alice. The container had a

number of large warning symbols on it which would clearly signify poison even to someone who could not read or write. I do not find that the deceased's inability to read and write had any bearing on his death.

[11] It seems to me that the deceased deliberately ingested the poison rather than face questioning by the police upon his detention. I cannot conclusively determine how much Phostoxin he ingested. Given the short timescales involved I have concluded that it was likely to have been one single tablet but I cannot rule out the possibility that it could have been more than one. Although a fraction of a tablet would probably have killed him, the lack of any trace of tablet residue anywhere suggests that tablets were not broken up before ingestion.

[12] It seems to me that he had at least three opportunities to ingest the poison and, from the evidence before me, I cannot conclusively determine on which of these occasions he ingested it.

[13] When the police first knocked on the door, a few minutes passed before the deceased answered it. This evidence comes from the police officers at the door and also from the deceased's wife and step-daughter Amy, who both made it clear that he shouted that the police were at the door and then went to the bedroom to put some clothes on.

[14] Then, once he answered the door to the police the deceased was asked to go and secure the three dogs. I consider that this was a reasonable request to make given the information outlined in the briefing about the presence of a possibly aggressive dog. He went out of sight of the police, (although the door was still open to an extent), for a short period of time while he secured the dogs.

[15] Finally, while the police were in the livingroom with the deceased he went to the kitchen and had some water. He was followed by a police officer, Detective Constable Fuller. While she confirmed that she could not see exactly what the deceased was doing, as he was larger than her, she was able to confirm that he went straight to the sink, filled a cup with water and drank it. She could not exclude entirely the possibility that he might have ingested the tablet at that time but she could with certainty exclude the possibility that he had gone to the kitchen cabinet where the

Phostoxin was eventually found, as that was quite some distance from the sink. This was apparent from the photographs of the house which were lodged, as well as the evidence of Police Sergeant Blakey and the deceased's wife. The deceased's wife thought it unlikely that he would have had time to take anything once the police were in the house. His stepdaughter Amy spoke to being able to see him drink the water from a cup.

[16] I consider that it was most likely that the deceased already had the tablet ready and available to take before the police officers arrived to execute the warrant and detain him. I have come to that conclusion for a number of reasons. He was expecting the police to come and detain him. His wife and step-daughter Amy both spoke to that. He was aware of the investigation. His wife and step-daughter Amy and police officers spoke to that. He said, as he was leaving with the police officers something along the lines that his wife and step-daughter would not see him again (the exact words given by witnesses varied, probably because it was only after the unexpected turn of events and the death of Mr McNally did they attach any significance to these comments). His wife and step-daughter Amy spoke to this as did some police officers. He had told his wife and step-daughter Amy that he was scared of prison. His wife and step-daughter Amy spoke to this. He eventually told the Accident and Emergency doctor that he had taken mole poison. This was spoken to by the Accident and Emergency Consultant, Dr Murphy and the paramedic, Mr MacDonald. Mole poison in the form of Phostoxin was found in the deceased's house. This was spoken to by Police Sergeant Blakey and the deceased's wife. It was a partially used container with only 9 tablets remaining. This was spoken to by the Rentokil operatives. It had been stored there for some time and was taken there from their previous home. His wife and step-daughter Alice both spoke to that. The deceased's symptoms were consistent with symptoms of Phosphine poisoning. This was spoken to by Dr Bouhaidar and the Rentokil operatives.

[17] I have concluded that the deceased probably took the poison on the first of the three possible opportunities (namely after police officers knocked on the door and before he answered it) as he was on his own during that period for some time. I cannot totally exclude the other two opportunities.

[18] It seems to me that while the deceased may not have been aware exactly how Phostoxin would affect him, he was aware that it was a poison and was likely to cause his death.

Police custody

[19] Inevitably, when there is a death in police custody the care which was given to the deceased while in custody is the subject of detailed and anxious scrutiny. I have not found any reasonable precautions that might have been taken by any police officers which might have avoided Mr McNally's death. Nor have I found that there were any defects in the systems of working followed by the police which contributed to his death.

[20] It appears that Mr McNally chose to take his own life on 13th August 2010 rather than face the serious allegations which had been made against him and which were being investigated by the police. Given the evidence before me in relation to the substance ingested by Mr McNally, it is clear that once Mr McNally had ingested the tablet, any and all attempts made to assist him and treat him, by police officers, ambulance paramedics and doctors, were likely to be in vain as he was almost inevitably going to die.

[21] In relation to the police and their care of the deceased while in their custody, it seems to me that once Mr McNally had ingested the Phostoxin tablet, there was really no going back and nothing that the police could have done, had they acted differently, would have made any difference.

[22] As I have been unable to determine exactly when Mr McNally ingested the tablet, although he probably did so before the police entered his home, I cannot see that the police would have been able to prevent him ingesting it had they acted differently at his home. Even if they had broken the door down and made a surprise entry (for example as happens in drug raids to stop evidence being disposed of) there is nothing to say that the deceased would not have had time to ingest the tablet then if he was already prepared. This type of entry could not be considered a reasonable precaution in circumstances such as this where a detailed risk assessment was carried out and no suicide risk identified. It would not be proportionate to the circumstances.

[23] The deceased was treated with dignity within his home. He was not handcuffed until within the police vehicle at his own request. There was no intelligence or information to suggest that he might be a suicide risk. His wife spoke to him never having mentioned suicide in the past. The police officers acted reasonably in asking him to secure the dogs given the available information and the potential risk to officers and other people present if aggressive dogs were loose within the premises. While he did leave their sight briefly to do this the police officers had no reason to suspect that he might take any harmful substance. The deceased went to the bedroom where the dogs were secured to dress fully before leaving with the police officers. He was accompanied by Detective Sergeant Ross who searched his clothes. He found nothing untoward.

[24] Police officers allowed him a cigarette and some water. It was a reasonable request (particularly given that a request for a cup of tea had been turned down because of the time limits put on detention periods) and a police officer quite correctly accompanied him to the kitchen and made sure that he went straight to the sink.

[25] When he became ill during the journey the police officers initially assumed that it was because he was being driven along a winding road and because of the stress of detention and the serious allegations made against him. Police officers spoke of sickness being a common reaction in these circumstances. The police officers asked him if he was on medication. He denied it. They asked if he had taken any substance. He denied it. They could not have known he had ingested Phostoxin.

[26] In any event, even if they had known, it is unlikely that anything would have saved him. Had he told them during the course of the journey that he had ingested poison, it is probable that he would have reached hospital quicker as I imagine they would have driven him straight there or arranged to meet an ambulance on the way, but, from the evidence before me, it is extremely unlikely that it would have made a material difference to the outcome. Dr Bouhaidar spoke to 40 to 70% of people who had ingested Phostoxin dying within 12 hours and 90 to 91% within 24 hours.

[27] Once in the cell block area at Burnett Road Police Station the acting custody Sergeant initially called for a police surgeon but immediately the deceased collapsed 999 was called. Police officers immediately rushed to the deceased's assistance and put him into the recovery position. It is clear from the evidence including the CCTV that I viewed that all police officers present in the cell block area reacted quickly and appropriately following his collapse as did the ambulance paramedic and technician.

[28] Given the evidence before me in relation to the substance ingested by Mr McNally, it is clear that once Mr McNally had ingested the tablet, all attempts made to assist him and treat him, by police officers, ambulance paramedics and doctors, were likely to be in vain as he was almost inevitably going to die.

[29] Finally, I should mention the actions of Police Sergeant Blakey and Police Constable Doherty, who should be commended for their quick thinking and cool heads in a stressful and fast moving situation. Their refusal to open the Phostoxin container when asked to do so quite possibly prevented others being contaminated and damaged by the toxin.

Conclusion

[30] In conclusion it appears that, sadly, Mr McNally was determined to take his own life and in furtherance of that aim ingested a lethally toxic substance probably shortly before his detention by police officers. This action could not have been anticipated by the police officers. Every effort was made to save his life at Burnett Road Police Station by the ambulance service paramedics and then by the medics at Raigmore Hospital, Inverness, but all attempts proved fruitless.

[31] I would wish to join with the procurator fiscal depute and solicitor for Northern Constabulary in extending my condolences to Mr McNally's family.