

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNFERMLINE

2014 FAI20

DETERMINATION

of

SHERIFF IAN R ABERCROMBIE, QC

into the death of

JAMES BELL

In terms of the Fatal Accidents and
Sudden Deaths Inquiry (Scotland) Act
1976

Appearances

Procurator Fiscal — Mr J O'Reilly, Crown Office and Procurator Fiscal Service

Fife Health Board — Mz L-A van der Westhuizen, Advocate

Scottish Ambulance Service — Mr C Paterson, Advocate

Police (Scotland) — Mr R I Macpherson, Solicitor Advocate; Simpson & Marwick

Constable Rhona Scott — Professor P Watson, Solicitor Advocate; Levy & McRae

Constables Robert McIntyre and David Barton — Mr R Vaughan, Solicitor Advocate;
RS Vaughan & Co

Mr James Bell Senior (the deceased's father) — Mr A Murdoch, Solicitor Advocate

Ann Hynd (the deceased's mother) — Mr M Thompson, Solicitor

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INTRODUCTION

[1] The Inquiry started almost 3 years after Mr Bell's death. The purposes of this Inquiry were, inter alia, to identify reasonable precautions which might have prevented his death, to consider defects in systems of working in place at the relevant time and generally to overview working practices with a view to future improvement. The delay in holding this inquiry has undermined these purposes.

[2] Understandably the memory of many witnesses was affected by the length of time that has elapsed since Mr Bell's death, despite many of them still being visibly affected by his untimely end. For example, as the procurator fiscal emphasised, it is regrettable that the precise content of the conversations between police and ambulance staff when they attended Mr Bell on the M90 in the early hours on 5 June 2011 can no longer be determined with accuracy. I have little doubt that had the Inquiry been held timeously, witness memories would have been fresher, particularly in respect of critical evidence about the interaction between the paramedics, Mr Bell, and the police. The Court would also have been able to make timeous recommendations about future precautions or changes in working systems.

[3] I was impressed by Mr Bell's family's tolerance of the long time it took to start the Inquiry and their dignity throughout the proceedings. The delay must have been intolerable for them. It is all too easy to forget the real human tragedy which underlies proceedings of this nature.

[4] I asked the Procurator Fiscal why it had taken so long to start the Inquiry. I was told he had no explanation to offer. I wish to stress that Mr O'Reilly took over this case at a very late stage and did his best to make up for lost time. His apology for the regrettable amount of time it has taken to bring this case to court is also noted. However, those responsible for the delay will I hope take note of my comments and do their best to ensure that in future Fatal Accident Inquiries are held timeously.

2. HISTORY AND SUMMARY OF EVIDENCE

[5] Mr Bell was born on the 2nd of January 1980. He lived, with his partner, in Cowdenbeath, Fife. He formerly experienced suicidal ideation - the last recorded incident being about eighteen months prior to his death. He was not prescribed methadone by his GP or the Fife NHS Addiction Service. He was not an opiate addict. He was a naïve user of methadone with the consequence that he had little tolerance to that drug. The only prescription he was on at the time of his death was for antidepressants (fluoxetine).

[6] Mr Bell was admitted from his home to Accident and Emergency at Queen Margaret Hospital at 01:18 hours on 4 June 2011 and again at 20:36 hours on the same day, following two separate methadone overdoses. On the occasion of his second overdose Mr Bell had arrested and required to be resuscitated by paramedics. He received injections of naloxone on both occasions. Naloxone is a known antidote to methadone. On the second occasion Mr Bell received a large amount of this antidote - 3rngs intramuscularly and 3mgs intravenously. This was the largest dose ever administered by the attending ambulance staff who had, between them, forty eight years' experience as technicians or as a paramedic.

[7] During his second admission Mr Bell was adamant that he wanted to leave the hospital and go home. He was warned that his life was at risk if he did so. He was told that he needed care and support in hospital, that his condition could deteriorate and that he was at significant risk of harm. Mr Roy, the A & E Consultant, was concerned that unless Mr Bell was observed there was a danger that he could become unconscious again when the naloxone wore off. This was because of the antidotes relatively short half life relative to methadone. (The half life of a drug is the time it takes for the plasma concentration to half). The possibility of Mr Bell developing a chest infection was a secondary concern. Dr Roy stated that on his second admission Mr Bell was not critically ill but that he was at risk of becoming critically ill.

[8] Dr Devine saw Mr Bell after he had been referred to her from the A & E Department.

Although she found no physiological symptoms of note she wanted him to stay in hospital for monitoring for at least twelve hours. She explained to him the reasons why - including the dangers associated with methadone overdose - and asked him to remain in hospital. She attested that Mr Bell had a Glasgow Coma Scale (G.C.S.) of 15. In her view, he was fully alert, able to take in, understand and process what was said to him. She considered that he had full capacity to make decisions about his life.

[9] Mr Bell did mention to her that he had family problems, and that he had wanted to die, although she qualified the note she had made to this effect in the medical records by adding that he said that he “felt alright”. She understood this to mean that he no longer felt suicidal. She did not form the impression that Mr Bell was suicidal or that he was eligible for detention under the Mental Health Act. In her view, he had no disordered thinking and no significant mental illness.

Nevertheless, she referred him to the Mental Health Team for assessment.

[10] Mr Bell was seen in A & E by a community psychiatric nurse, Ms Traill, for about ten minutes. A full psychiatric assessment would have taken about 45 minutes. Mr Bell mentioned to her that he had family issues, having been in foster care and Rimbeldon, which I understand to have been a List “D” school. He explained to her that the reason he had taken methadone overdoses was ‘stupidity’. He said he did not have any current suicidal thoughts. Nurse Traill thought Mr Bell had “thought better of” taking methadone earlier and that is why he agreed to a full psychiatric assessment later that day. Mr Bell kept falling asleep during this assessment, was embarrassed because he did not have his false teeth and became annoyed with Nurse Traill for waking him.

[11] This nurse was unable to complete her assessment. However she formed the view that Mr Bell did not have any on-going suicidal ideation. She based this assessment not only on what he had said to her, but also her general observations of him as an experienced nurse. Nurse Traill concluded that Mr Bell was not at risk of further self-harm at that time. She had no concerns about his capacity;

in essence, to understand what was said to him, to process that information and make up his own mind. She ended her assessment by arranging that Mr Bell would come in for a full assessment later that day.

[12] Before he self-discharged from hospital Mr Bell was also seen by Dr Ng. She wanted, like her colleagues, to keep Mr Bell in hospital to monitor his respiration and consciousness because she was concerned that the naloxone would wear off before the methadone did, that Mr Bell could relapse into the same state of unconsciousness as he was found in at home, and that he could die if he was not found. She specifically warned him of these dangers. She too was of the view that Mr Bell had a G.C.S. of 15 and had full capacity. Mr Bell insisted that he wanted to go home.

[13] Julie Barlow, who completed Mr Bell's self-discharge, had no recollection of doing so. She however confirmed that it was her usual practice to be very blunt whenever a patient signs a self-discharge form. She would normally leave patients under no illusion about what would/could happen to them if they left against medical advice. Mr Bell self-discharged from the hospital at about 2.00am.

[14] Thereafter, there is a period of several hours where Mr Bell's movements and activities are not precisely known. We do know that at some point he met up with Mr James Wallace. He and Mr Wallace were not known to each other. The precise circumstances of how this meeting came about are uncertain as Mr Wallace's evidence was confused and contradictory. Trying to piece his evidence together as best I can I suspect they met for the first time outside the A & E Department of Queen Margaret Hospital. Mr Wallace had also been attended to by a Scottish Ambulance Services paramedics at about 00:35 hours on 5 June. They responded to an emergency call from the Shell Garage, Halbeath Road, Dunfermline, where they found Mr Wallace sitting on the ground. One of the ambulance crew formed the view that he had been drinking. There was a strong smell of alcohol coming from him.

[15] Mr Bell and Mr Wallace were subsequently seen by passing taxi driver on the M90 motorway. The taxi driver reported seeing two pedestrians on the M90 northbound at 05.33 hours on the 5th of June 2011. Shortly beforehand, at 05:25 hours, a police control centre operator answered a call from an emergency telephone located at junction 2A, southbound on the M90. The caller said he was lost and trying to make his way back to Cowdenbeath. He said he was with a friend. At about 05:30 hours a further call was received from another emergency telephone on the opposite side of the motorway, at the same junction, northbound. The caller was a different male who confirmed that his friend had just called.

[16] PC Barton was the first police officer to arrive at the northbound motorway junction 2A to find that Mr Bell and Mr Wallace were essentially lost. He said that Mr Bell was in a “zombie like” state, and “far away”. Mr Wallace was more alert. PC Barton noted a smell of alcohol from both men, particularly Mr Bell. He placed both men in his vehicle for safety. PC Barton was concerned about Mr Bell’s condition - he kept on falling asleep - and called for an ambulance and police back up.

[17] PC Barton also asked his Force Control Centre to check whether Mr Bell may have walked out of hospital as he had what appeared to be an intravenous site on his left arm and a hospital wrist tag. (This radio call was made at 05:49 hours). Six minutes later Constable Barton asked control whether his control had a response because he was becoming increasingly concerned about Mr Bell’s condition. After contacting a receptionist for NHS Primary Care Emergency Services the control centre operator¹ informed Constable Barton that Mr Bell had been admitted on 4 June and discharged on the same date. The information passed to Constable Barton did not mention that Mr Bell had been readmitted to hospital later that day with a second overdose nor that he had subsequently discharged himself against medical advice.

¹ (Crown production no 23 is the agreed transcript of the conversation which took place between the controller and the operator)

[18] PC Barton was subsequently joined on the M90 by a paramedic Angela Kay and by a colleague PC Nisbett. Ms Kay was in a paramedic response vehicle. She found Mr Bell conscious and breathing with a strong radial pulse. As she was aware an ambulance was en route, with facilities and equipment to examine Mr Bell, she awaited its arrival and then left.

[19] On arrival of the ambulance, Mr Bell was escorted to it and examined by Mr Basden, the paramedic. Mr Basden was accompanied by Mr McArthur, an ambulance technician. (For ease of reference I will subsequently refer to them as 'paramedics').

[20] Both paramedics had attended Mr Bell in response to his previous methadone overdoses.

[21] Mr Basden examined Mr Bell at Junction 2A. Mr McArthur had peripheral involvement with the patient, as he was carrying out other duties.

[22] Mr Basden carried out the usual observations and tests to be expected in such circumstances and made a contemporaneous record of his clinical findings. He established that Mr Bell's pulse was 'slightly high' (100) and that his temperature was also "slightly high" (38.6)². His pupil size and reaction was normal. In his evidence, Mr Basden stated that Mr Bell did not appear to be drowsy or dazed, although he looked, not unsurprisingly given the hour and what had happened to him in the preceding hours, tired. He did not think that Mr Bell seemed intoxicated - or that he smelled of alcohol. He was told by Mr Bell that he had not taken drugs. In his view, Mr Bell was able to understand what he was saying, retain that information, understand it, and use it to decide what he should do. He had no doubt about Mr Bell's capacity to make decisions for himself.

[23] Mr Basden was concerned about Mr Bell's raised temperature and the associated risk of possible infection. He warned Mr Bell about this risk and that if he did not get treatment, he could die. He also told Mr Bell that he was concerned about his history of methadone overdose and that

² At another point in his evidence Mr Basden described Mr Bell's temperature as "quite elevated.., we term it pyretic". He described Mr Bell's blood pressure as "borderline high".

he wanted him to go to hospital in respect of that. Mr Bell refused transport. Mr Basden recorded his observations on no 8 of process, the e-pacer patient report. Under the heading "Final observation and comments" he recorded:

"MALE SELF DISCHARGED FROM CAS (Casualty) AFTER EARLIER O/D (overdose). FOUND WALKING DOWN HARD SHOULDER OF M90. ON ARRIVAL, SITTING IN BACK OF POLICE CAR, FULLY CONSCIOUS AND TALKING. OBS (observations) APPEAR WITHIN LIMITS. PATIENT IS REFUSING TRANSPORT TO HOSPITAL AT THIS TIME. REFUSAL FORM SIGNED. PATIENT APPEARS TO BE SAFE TO BE LEFT WITH POLICE AT THIS TIME WITH THE ADVICE TO SEEK MEDICAL ASSISTANCE IF REQUIRED."

Mr Bell signed a part of this electronic document, "agreeing" that he had declined an offer of treatment/transport - with the word transport highlighted - and accepting "full responsibility for this decision".

[24] The evidence about what the constables were told by the paramedics was disputed - not surprisingly so given the length of time that has passed since Mr Bell's death. For example, PC Barton said he was told by Mr Basden that Mr Bell was fit for detention, and need not go to hospital. He said he was not told that Mr Bell had refused to go there. Mr Basden disputed that and maintained that he had told the constable that he would like him to go to hospital and Mr Bell had refused. PC Nisbet's version of events was that he had a recollection of being told that Mr Bell did not want to go to hospital. He did not hear Constable Barton being told that Mr Bell was fit for detention.

[25] There was also a dispute in the evidence I heard about the extent of Mr Bell's physical condition - and whether Mr Bell was in fact under the influence of drink.

[26] Some time was spent at the Inquiry exploring these matters.

[27] The evidence about Mr Bell's physical state when on the M90 was unclear. My overall impression of the evidence was that the attending police officers were not as certain in their

evidence on this issue as they had been when questioned earlier in preparation for the Inquiry. That could be partly attributable to the delay in hearing this case. There were also some discrepancies in the findings of the first paramedic to arrive at the motorway locus, and the accounts given by Mr Basden and Mr McArthur. I do not consider, for example, that Mr McArthur's description of Mr Bell as "tired and drowsy" necessarily contradicts Mr Basden's description of him as "fully alert" particularly given the lateness of the hour, what Mr Bell had experienced in the immediately preceding hours, and the different times which these individuals spent with him. Overall I prefer the evidence of Mr Basden. I find that at the time of his examination in the ambulance Mr Bell was fully awake and orientated. I do not accept that there is any real doubt about the observations, both medical and visual, recorded by Mr Basden in Crown production 8, the E-pacer Patient Report. In light of this finding, I do not consider the disputed evidence about Mr Bell's state of impairment prior to his examination by Mr Basden particularly germane.

[28] In respect of whether or not the paramedics were "certifying" Mr Bell as fit for police detention or "certifying" him at the time they saw him as safe to be left with the police, I favour the latter interpretation - for three main reasons. Firstly, it is what the form itself actually says. Secondly, that interpretation was confirmed by both Mr Leigh-Smith, a consultant in Accident and Emergency medicine and Dr Hiremath, the then Fife Constabulary's Force Medical Examiner. They were both of the view that ambulance service personnel could express a view on whether a patient could remain with the police - but not whether he or she is fit to be detained. They advanced sensible reasons for this view — which included the Service not knowing how long a person might be in custody. Thirdly, Mr Basden gave clear evidence that paramedics had been instructed that the question of whether or not someone was fit to be detained was a "medical/legal decision, and p a question for paramedics to consider. In my view, this instruction may have had the unintended consequence of making the paramedics reluctant to alert the police to the medical risks which Mr Bell faced. This is a question which I will return to when considering section 6(1)(d) of the Act below.

[29] After Mr Bell signed the disclaimer section of the E-pacer Patient Report, and following further conversation with the paramedics the constables in attendance entered the ambulance, where Mr Bell had been examined, and charged him with being drunk and incapable. A police van was called to transport Mr Bell to the police station. CCTV footage of the journey to the police station shows Mr Bell constantly falling asleep.

[30] Mr Bell was taken into custody at the police station. There is CCTV footage showing him at the charge bar. He is seen to sway. He almost fell asleep on several occasions. However, he was able to answer the vulnerability assessment questions asked of him by the duty custody sergeant. He said he had drunk “whisky and a couple of tins of beer”. He was assessed as a special risk due to his being under the influence of alcohol. This status was duly recorded in Mr Bell’s computerised “cell file” record. He was placed on a regime requiring him to be observed every thirty minutes.

[31] Because Mr Bell was assessed as being drunk and incapable he would normally have been placed in an observation cell, which has camera surveillance. There were two such cells in Dunfermline Police Station at the time but both were already occupied. The duty sergeant checked to see if observation cells in Kirkcaldy or Glenrothes Police Stations were available, but all such cells were occupied. Mr Bell was taken to cell 11 by PCs Barton and Nisbet where he put on the suicide suit provided to him.

[32] I address the criticisms of the admission and observation procedures in Dunfermline Police Station and the circumstances surrounding the issue of the E pacer Patient Report to the police by the paramedics attending Mr Bell on the motorway in more detail below. I consider these are the two essential matters which arise in this Inquiry.

[33] It follows that I have no criticism to make of the paramedics who attended Mr Bell’s home on 4 and 5 June 2011 and who saved his life on both occasions. Nor, do I have any criticism to make of the system of working in Queen Margaret Hospital³ or of the various police officers in respect of

³ See however the matters I refer to below in terms of section 6(l)(e) of the 1976 Act.

their motorway attendance. I also have nothing to say about the conduct of the officers who subsequently transported Mr Bell to the custody suite or about the paramedics roadside examination — save in respect of the matters I return to below surrounding the E pacer Patient Form.

[34] Indeed I emphasise that Mr Bell's treatment by those involved in attending him at home, at the hospital and the roadside, were in many respects exemplary.

3. ADDITIONAL WITNESS ASSESSMENTS

[35] I found all witnesses did their best to assist the Inquiry, given the difficulty I have already highlighted. Mr Leigh-Smith revised and tempered his original expert report in light of the additional information given to him. I have already commented on Mr Wallace's evidence. I accept that the custody sergeant's evidence was in part contradictory, particularly in respect of her risk assessment of Mr Bell. I found the evidence of the PCSO Bettley less than satisfactory. She gave contradictory and at times confusing evidence. However, I entirely accept her evidence in respect of her lack of formal training.

[36] I wish to commend Dr Ng, for the frank and open way in which she gave her evidence. I accept that it is not always possible in a busy A & E Department to make contemporaneous notes and as Mr Leigh-Smith stated this is always a matter of judgment and balance. I imagine that anyone who was a patient in A & E would prefer doctors to focus primarily on their treatment rather than on making notes!

4. SECTION 6(1)(a) THE TIME AND PLACE OF MR BELL'S DEATH

[37] Mr Bell was found to be unresponsive by the custody sergeant in cell 11 of the custody suite of the police station at Carnegie Drive, Dunfermline at 18:54 hours on 5 June 2011. He was taken to Queen Margaret Hospital Dunfermline by ambulance in cardiac arrest and was pronounced dead there at 19:37 on that date.

[38] Although it is not possible to be certain of the exact time and place of Mr Bell's death, I conclude (based on the evidence of Dr Roy and the custody sergeant and the medical records (Crown production 2, page 21) that Mr Bell died in his cell shortly before 18:54 hours⁴

5. SECTION 6(1)(b) THE CAUSE OF MR BELL'S DEATH

[39] Although the toxicological analysis of Mr Bell's blood revealed the presence of other drugs, primarily diazepam and phenazepam, which would have a cocktail effect, with methadone, in contributing to Mr Bell's death, I am satisfied on the evidence, particular that of Dr Roy, Mr Leigh-Smith and Dr Sadler, that the primary cause of death was most likely to have been methadone overdose.

[40] Dr Sadler said that he was not sure whether the relatively low level of methadone found in the toxicological analysis indicated that Mr Bell had metabolised most of a single large dose of the drug, or whether he had taken more than one dose. Mr Roy and Mr Leigh-Smith thought it likely that Mr Bell had taken a further dose of methadone prior to his second admission. I accept their evidence in this respect.

[41] I consider that bronchopneumonia was likely to be a significant factor contributing to Mr Bell's death, because of its association with his drug use. As is noted in the post mortem report, bronchopneumonia can develop or worsen rapidly during the prolonged agonal period of coma associated with drug-related deaths. As was explained to the Inquiry, drug intoxication and its effect on breathing can worsen and hasten the development of pneumonia, and as pneumonia in turn affects the symptoms of methadone ingestion, a "vicious cycle" is created.

6. SECTION 6(1)(C) THE REASONABLE PRECAUTIONS, IF ANY, WHEREBY MR BELL'S DEATH MIGHT HAVE BEEN AVOIDED

⁴ A police custody support officer (Stewart) who had recently come on duty, said that he believed he saw Mr Bell's chest moving at 18:51 when he had a quick look into Mr Bell's cell through the observation hatch. As Mr Stewart's evidence was so uncertain, I cannot attach much weight to it.

[42] I have considered whether to deal with police failure to observe Mr Bell in accordance with their specified procedures. (see pages 18-25 below) in terms of this section of the Act.

[43] The words ‘reasonable precautions’ might well include the implementation of observation measures identified before Mr Bell’s death, with a view to achieving the result they were aimed at delivering — essentially that if his condition deteriorated, medical assistance could be rapidly obtained. I consider however that the 1976 Act differentiates between a system not being in place at all and one not being implemented or operated properly. For this reason, in this Inquiry I will consider the matters arising under this section of the Act as a “systems defect”.

[44] As Mr MacPherson observed during his closing submission, this distinction may not have any practical effect — particularly given Police (Scotland)’s position, as noted below.

[45] Lest there is any doubt on the matter, if I had made a determination in terms of this subsection, I would have found that Mr Bell’s death might have been avoided, if the police had taken the reasonable precaution of implementing their system of observation.

Section 6(1)(d); The defects in any system of working which contributed to Mr Bell’s death

[46] When considering this subsection of the 1976 Act I will focus in particular on the events which occurred on 5 June 2011 in Dunfermline Police Station.

[47] At the outset, I note Mr MacPherson’s ready acceptance of the defects in the system in operation at the time, that the standard of care fell below that which was to be expected, and that this determination will be seriously considered, notwithstanding the recent reorganisation of the police force. Given this attitude, which is novel and commendable, I do not intend to focus on the individual failures which occurred. I agree with the Procurator Fiscal that there is nothing to be gained by such an approach. However I do wish to stress that there was not simply a failure of individual officers — but also a failure by those charged with managing the system to take any steps to see that specified procedures were being implemented. For this reason I do not consider the wholesale blame placed on the staff on duty in the police station justified.

[48] Although the police officers taking Mr Bell into custody were aware that he had previously overdosed on methadone, they were not, unsurprisingly, aware of the effect of the long half life of methadone, nor were they aware he was possibly suffering from an infection, both of which could result in respiratory depression. Even though he was placed on half hourly observations, I have little doubt that those working in the custody suite proceeded on the basis that he was drunk and incapable and were simply waiting for him to sober up before releasing him. It is clear to me that the observations which were carried out were done less frequently than were required on the assumption that Mr Bell was, as time progressed, sobering up. In reality the alcohol in his system may well have been reducing, but the effect of methadone in his system was not.

[49] In 2007, Fife Constabulary, as it then was, issued a document entitled “Custody Care — Standard Operating Procedures” (hereinafter referred to as “the Manual”). The document extends to 134 pages, is comprehensive and specifies in detail “the standards that Fife Constabulary has set for management, care and welfare of all persons in police custody”.

[50] On admission to custody Mr Bell was placed on “Intermittent observation requiring him (my emphasis) to be “visited and roused at least every 30 minutes” It is clear that Mr Bell was not visited and roused at least every 30 minutes.

[51] The evidence from the custody officers and the police custody security officers (PCSO5) was to the effect that if a custody responded to the observation hatch being opened — by turning over or “grunting” or opening their eyes — that was sufficient to comply with this level of observation. The Manual also specifies, under the same heading, that “the custody is positively engaged at frequent and irregular intervals”. I do not consider the brief perfunctory glances into Mr Bell’s cell as fulfilling the requirements which were specified and required for Mr Bell whilst he was in custody.

[52] It is also clear that at least one visit to Mr Bell’s cell is recorded as having been made when in fact no such visit was made. The discrepancy between the CCTV footage and the custody log in this respect was not satisfactorily explained to me by any witness. No one accepted responsibility for

this entry. Although the log entry was made under the name of the PCSO on duty at the material time, she was anxious to explain to the court that she did not “log out” of the computer after recording each visit. Just how this entry came to be made is accordingly somewhat of a mystery — although I am prepared to accept the evidence of PC McIntyre he would not make an entry in the log under someone else’s name and that no one else in the station at the material time, who had access to the PCSO computer, would have had an interest in making this mythical entry.

[53] The duty PCSO did explain in her evidence that she had limited time to carry out observations, as the cells were fully occupied, She also had extensive duties elsewhere, including finger printing incoming custodies. The custody suite was one member of staff short during the day shift. She also alleged that she had received no training in respect of the contents of the manual — apart from “on the job” training from colleagues, and was due to start her first custody training course several weeks after Mr Bell’s death, by which time she had already been in post for several months.

[54] In light of the above, I draw attention to the following defects in the system of working in Dunfermline Police Station which contributed to Mr Bell’s death. (Again for the avoidance of doubt, had I considered these defects in terms of section 6(1)(c) of the Act as precautions whereby Mr Bell’s death might have been avoided, I would have found them to be “reasonable” because they arise directly from the operation of the Manual. Such procedures would, no doubt, not have been specified in the first place had they not been costed and considered capable of being implemented). All these issues all arise from consideration of the evidence and were outlined during discussion of Mr Macpherson’s closing submission.

1) The Manual is too lengthy and not as focused as it could be. The operational sections of the manual could perhaps be highlighted — particularly in respect of the important functions to be fulfilled by PCSOs. The operational requirements could be distinguished from the descriptive or educational parts of the manual. (For example, section 11 — “Awareness Guide to Medical

Conditions” might be regarded as a standalone, ‘descriptive’ section). While what I have called the descriptive parts are no doubt important in training those who are responsible for custodies, the ‘operational duties’ which specify what requires to be done are not given the prominence which I think they deserve. I also find the language used in the operative part of the manual opaque and repetitive. All custody staff, and in particular the custody sergeant responsible for carrying out the risk assessment on people’s admission to custody should have a real awareness of the Manual, the purpose behind issuing it, a working knowledge of its provisions and the likely consequences of failing to follow it. For example, the custody sergeant professed at one point in her evidence to know nothing about methadone and its effects — despite the manual containing clear information about that substance. Furthermore, the operational provisions of the manual should obviously be properly implemented. This was not done to any real extent in this case. Even the requirement to provide meals to Mr Bell was not followed.

2) All custody suite operators should be properly trained before taking up their duties. There was a complete lack of comprehension on the part of the PCSO on day duty about what she should be doing⁵ She had no proper awareness of the Manual and its operating procedures. “On the job training” for such a responsible position is, to my mind at least, inadequate. There was no reason given to the Inquiry why the PCSO in question had not been sent on the training course specifically set up to equip her to understand her duties. The staff’s awareness regarding handover procedures between shifts appeared to be, at best, uncertain. Sergeant McIntyre was not aware - through no fault of his own — that the PCSO on duty was untrained.

3) The custody suite should be adequately and sufficiently staffed.

4) PCSOs should be properly supervised. If duties are not being performed in accordance with the Manual, then staff should be encouraged to say so. Supervision should amount to something more

⁵ Her shift also extended into the evening of the 5th June 2011.

than simply asking, as I heard in evidence, “is all in order”. The assumption of knowledge of procedures on the part of the PCSO was entirely misplaced.

5) The amber and red alerts, which respectively appear on the cellfile when a supervisory visit is due, and then overdue, should only be capable of being removed from the computer log when an identifiable staff member has specifically logged on to make an entry recording that an observation visit has taken place.

6) Many of the “supervisory visits” to Mr Bell were recorded as “cell in order”. This was apparently an option which it is possible to select from a drop down menu. As is obvious, such an entry is meaningless. It is not the state of the cell which is relevant — regardless of what meaning that phrase came to mean by those using it. Consideration should be given to making the custody officer make a short individual entry in the observation log based on his or her actual observation of the custody rather than simply selecting one option from a standard list. Such a step might encourage actual observation of the custody, and avoid a situation whereby a mere cursory glance through the observation hatch is deemed sufficient for someone on ‘intermittent observation’.

7) Observation visits should be logged immediately after each cell visit has taken place. Witnesses spoke to visits being logged in cumulo — often many minutes after visits have occurred. At the material time there were at least three other custodies apart from Mr Bell on “intermittent observations”. In my view it is a real feat of memory for the wellbeing, or otherwise, of these custodies to be accurately recorded — particularly if observations are taking place in conjunction with “general observation” visits to another eight cells and custodians are diverted, for example to fetch water, during such visits. I do not know whether it would be possible to record visits to custodies on a heightened level of observation by having a more centrally based computer terminal, or by using a portable device or by recording visits in a different way, for example, on the marker

card/record outside each special observation cell. These are only possibilities which others may wish to consider when considering the implementation of a system of observation which actually works⁶

8) The meaning of the word “roused” appears to have been interpreted by custody staff in the way I have outlined generally in paragraph [51] I cannot understand how this word came to have been given such a meaning. The Manual specifies for four different levels of observation for people in custody. “General Observation”, includes the direction that “staff need not wake a sleeping custody” during the hourly visit specified for such low risk custodies. “Frequent Observation”, where a custody’s risk assessment indicates a risk of self-harm, includes requirements that the “custody is under frequent observation ...” and is positively monitored at frequent and irregular intervals.” As has been noted “Intermittent Observation”, which is the next highest level of risk (before “Constant Observation”) also specifies such positive engagement and in addition requires the custody to be “visited and roused at least every 30 minutes”

[55] When read in conjunction with the requirements for the other level of observations specified in the Manual, these particular words can only mean that the custody is woken up. I cannot understand how the word “roused” could be given any other meaning in the context of the Manual as a whole. Dr Hiremath, the Force Medical Examiner appeared to agree with my interpretation. Whether this word requires to be further defined or changed in any future edition of the Manual is a question which I leave for future consideration.

[56] The Inquiry only saw and heard on the CCTV footage perhaps two examples of Mr Bell being roused properly. One was at about 14:16 hours, when Sergeant McIntyre entered Mr Bell’s cell and called out his name on eight separate occasions before Mr Bell woke, and answered him. The other

⁶ Mr Murdoch suggested that Mr Bell’s care plan should have been recorded in an identifiable and comprehensive format, in a separate identifiable location rather than simply as an entry in the cellfile report. I heard insufficient evidence to comment further on this matter, but nevertheless repeat this suggestion here as one which may deserve further detailed consideration in light of the Chief Constable’s willingness to consider all relevant matters.

was at about 11.25 hours when Rhona Scott entered the cell and shouted his name. These examples are in sharp contrast to recording an involuntary response to the observation hatch being opened — which is what I think several witnesses described.

[57] Mr Bell was certainly not roused at the prescribed intervals in the way that the Manual requires. It is obvious that urgent consideration must be given to what should be done to properly check high risk custodies such as Mr Bell and to ensure that the specified system is properly implemented.

8. SECTION 6(1)(e) ANY OTHER FACTS WHICH ARE RELEVANT TO THE CIRCUMSTANCES OF MR BELL'S DEATH

[58] There is one pre-eminent matter I wish to emphasise before turning to consider other facts which are relevant to the circumstances of Mr Bell's death.

[59] As noted, the E-pacer Patient Report issued by the paramedics stated that Mr Bell "appears to be safe to be left with police at this time with the advice to seek medical assistance if required". It is clear to me that this statement, at best, understated the position. Mr Bell was a sick man. Firstly he had taken two methadone overdoses within about 36 hours of being arrested. Both overdoses required him to be admitted to hospital. Before each admission he had been treated by the same paramedics who subsequently examined him on the motorway. On the second home visit, the paramedics administered the largest dose of naloxone ever to be administered by them.

[60] Both paramedics were aware that Mr Bell had an elevated temperature and pulse rate which might be indicative of an infection, and, which, unless treated with antibiotics, could be life threatening. Mr Basden warned Mr Bell that, unless his "possible infection" was treated, it could get worse and Mr Bell could die.

[61] In addition, Mr Basden who was the leading member of the ambulance crew, was concerned, albeit to a lesser extent, about the lasting effect of the methadone overdoses. In response to a question by the procurator fiscal about whether he was concerned whether there

might “still be stuff in his system”, Mr Basden responded that it was “ at the back of my mind” and that was “why he wanted Mr Bell to go to hospital”. At an earlier stage in his evidence he said he was concerned about Mr Bell’s methadone overdose —“that and the temperature”. During cross examination by Mr Watson, Mr Basden indicated that he was aware of the half life of methadone — which he thought was about 24-36 hours. He accepted that it was competent to have a “clear picture” not only about the half life of this substance but also whether it was “in play” at the time he was examining Mr Bell. He agreed with the proposition that the half life risk of methadone was important because it could cause someone to lapse into unconsciousness and could result in death such “as has occurred’.

[62] At one point during cross examination Mr Basden qualified an answer about Mr Bell being affected by methadone in his system when the antidote wore off by stating that he would not expect this to happen given the length of time which had elapsed since he and Mr McArthur had administered naloxone. This answer was challenged by asking the witness about his knowledge of the half life of methadone given that Mr Bell had received the antidote and self discharged from hospital less than twelve hours before he was examined on the motorway. I found Mr Basden’s attempt to qualify his previous answers in this respect disingenuous. Considering his evidence as a whole, I find that he was aware that Mr Bell could have been affected by methadone still in his system when the naloxone in his system wore off.

[63] Like Mr Basden, Mr McArthur considered that Mr Bell needed to go to hospital because of his raised temperature and borderline raised pulse rate. He thought these symptoms meant that Mr Bell was suffering from a possible infection which could be life threatening. When he was asked about methadone and its known symptoms, he said it was an opiate. When asked about its particular dangers, he stated he did not know what the question meant. He did not appear to know anything about the half life of methadone, and whether or not it had a shorter or longer half life than heroin. He had no concern that methadone may still have been in Mr Bell’s system at the time

of his motorway examination. I found certain of Mr McArthur's answers surprising, and also surprisingly divergent, from those given by Mr Basden. This is a matter I will return to.

[64] In the particular circumstances of this case Mr Basden's knowledge about the half life of methadone being longer than the half life of naloxone, may not have been of any practical importance, because he was aware of the risk of Mr Bell developing a lung infection and consequences of that.

[65] What I think is important is not the different nature of the risks which Mr Bell faced, both of which, as it so happened, required him to be observed, but that the paramedics should have communicated to the police that Mr Bell's medical condition was at risk of deteriorating and if it did so, his life could be threatened. At the very least, they should have alerted the police to the serious possibility that he could develop a lung infection which could affect his breathing.

[66] It was accepted in evidence that police officers would not, nor would they be expected to, know that Mr Bell's elevated temperature and pulse might indicate early signs of a lung infection/pneumonia.

[67] Mr Basden accepted that no medical advice was given to the police. He had no recollection of anything being said to them about Mr Bell's future treatment. He appeared to suggest at one point in his evidence that the last sentence under the heading of "Final Observation and Comments" on the E-pacer Patient Report, put the police on notice that Mr Bell may well require future medical treatment. I disagree. The words used cannot stretch to encompass this suggested meaning. In fact, at another point in his evidence Mr Basden suggested that the "advice" in question only meant that the police should call the ambulance service or the Force medical examiner if required. He fairly accepted when cross examined by Mr Vaughan that he gave the police no medical advice about Mr Bell's ongoing care, and when questioned by Mr Thomson agreed that it would have been helpful, in hindsight, to have given the police fuller information. While Mr Basden's recollection was uncertain, quite understandably given the passage of time and while he spoke to his usual practice in similar

circumstances, I am satisfied that the parties criticisms in this respect of this matter were properly put to him for his comment.

[68] In my view, the comment that the patient appears to be safe to be left with police at this time was insufficient — given the risk of future deterioration in Mr Bell’s condition. The “advice” to seek medical assistance if required does not in my view sufficiently alert the police to a known risk of change in Mr Bell’s condition — and in particular to the fact he may develop a lung infection which could lead to respiratory difficulties.

[69] Even the interpretation of these words to the effect that the police should call for medical assistance if concerned, does not alert the police to the risk factor identified. I accept Mr Leigh-Smiths evidence that the paramedics should have informed the police about the risk they recognised and provided, if not guidance as to the observations required for Mr Bell, at least a warning to the effect that he required to be carefully observed.

[70] I accept that the paramedics did not know how long Mr Bell was to be in police custody. However the very fact of this uncertainty should have alerted them to the necessity of warning the police about the known risk that Mr Bell’s condition might deteriorate.

[71] I also accept Mr Leigh-Smiths evidence that one of the most important ways of transferring information between agencies can be by verbal communication. That is why I emphasise that this information should have been stated in the E-pacer Patient Report or given verbally to the police — and preferably, both methods should have been employed. I do not consider that my views contradict the dangers highlighted in Mr Murdoch’s submission to the effect that verbal communications may be misunderstood, misheard, lost in translation etc.

[72] The National Memorandum of Understanding between the Scottish Ambulance Service and the Association of Chief Police Officers in Scotland, which on the evidence of Mr Anderson,

supersedes Crown Production 1 1⁷ provides, in respect of the management of people who are drunk and incapable that it is a common purpose of the document:

“2.1. (iii) To ensure that all relevant information is consistently gathered, ... and exchanged appropriately.”

I do not think that in this case all relevant information was appropriately exchanged between the paramedics and the police, to the extent that I have specified.

[73] I can readily understand in light of what is said above on pages 12 and 13 why the paramedics may have been under the impression that they were only assessing Mr Bell's condition at the time they examined him - and that they believed that he would be under regular observation in custody where there is ready access to medical assistance. However, in my view, that should not have prevented them from indicating to the constables their real concerns about a possible deterioration in Mr Bell's condition.

[74] It is in no one's interest that relevant information should not be disclosed on the basis that a medical assessment is only valid for the period at which it is made. If the arguments I have heard at this Inquiry are anything to go by, I suspect that an element of such thinking may have crept into the system. I hope that further consideration will be given to this matter. The extent of any liaison between the ambulance service and the police has not been explored in the evidence but I note that the National Memorandum of Understanding provides for regular review of the guidance.

[75] In fairness to the ambulance service I am conscious that in this case that even if an appropriate warning had been written on the E-pacer Patient Report the arresting officer at the scene and more importantly the custody sergeant, carrying out the risk assessment to determine inter alia the level of observations Mr Bell required, may not have read it. There was commendably a

⁷ Drunk & Incapable Persons — Protocol between Fife Constabulary and the Scottish Ambulance Service

frank admission from Constable Barton that he did not. The evidence suggests that this document came to be regarded simply as another form. The custody sergeant barely even glanced at it. (This underlines the point I make above about the importance of verbally transmitting information as well as doing so in writing). I suggest that the perception of those using this form should be reviewed and changed. If no patient and carer form is uniformly issued to the police (as is done routinely when someone is left with a friend or relative) and if this practice is not to change, then the importance of considering the E-pacer Patient Report and acting upon it, is obvious⁸

[76] My impression of the way this Report was considered by witnesses is highlighted by the fact that for a large part of the Inquiry it was referred to as a “Treatment Refusal Form”. In my view, it was and should be much more than that.

[77] I am also conscious, again in fairness to the Ambulance Services, that in this case, even if the relevant information had been given to the police, it may well not have resulted in Mr Bell being observed properly, given what I have just said about the defects in the implementing observation regime in Dunfermline Police Station⁹ Accordingly I cannot conclude, on the evidence I heard, that the defects identified in respect of the E-pacer Patient Report in the particular circumstances of this case, contributed to Mr Bell’s death. That is why I have dealt with this matter in this section of the Determination as opposed to dealing with it in terms of section 6(1)(d) of the Act. However I have found this a difficult decision to make and one which is not free from doubt.

[78] I now turn to other matters which I consider relevant to Mr Bell’s death.

⁸ See also page 38 below

⁹ Mr Basden undoubtedly thought that Mr Bell would be observed regularly whilst in police custody. In this respect he was unfortunately very much mistaken.

(1) Mr McArthur's knowledge of methadone, and of naloxone and their respective half lives, differed markedly from that of Mr Basden. In this case this may not have been of less practical consequence than it might otherwise for the reason I have previously specified¹⁰ However, Mr McArthur does treat many patients who have overdosed on methadone. He said about 8 annually. The divergence in the knowledge of these two witnesses does cause me concern. Given the evidence I heard from Mr Leigh-Smith, who has expertise in this area, and from Mr Basden, I would have expected Mr McArthur to have greater knowledge of the effects of methadone overdose and its treatment.

The cause of this discrepancy may be due to a number of factors, such as training issues or to Mr McArthur's reluctance to be more forthcoming in the witness box. These matters were not explored in any detail at the Inquiry and accordingly I will not say anything further.

(2) As noted, when Constable Barton asked for information about Mr Bell's previous treatment in hospital, the information relayed from the A & E reception to his control was that Mr Bell had been discharged on the morning of the 4th June. The updated information that he had self discharged a few hours earlier did not appear to be available and was not given to him. While the exchange of information that did take place is to be commended — I also think it relevant that the information should have been up to date. Those responsible for keeping the records in question may wish to consider if and how this can be done. I am of course conscious in making this point that Mr Basden was aware that Mr Bell had self discharged — as is recorded on Crown production 8 — nevertheless I still consider that this point is relevant in terms of this section of the Act.

¹⁰ See paragraphs 64-65 above.

(3) The risk assessment procedures carried out at the charge bar at Dunfermline Police Station should also be reviewed. Mr Bell was noted to be suffering from asthma and was on a prescription for fluoxetine. Apart from noting these conditions, no attempt was made to explore or consider them further by, for example, considering whether or when he next required any medication. I agree with Mr Paterson's criticism that the custody's sergeant's evidence about these matters was contradictory, and that her actions did not accord with the Manual.

9. PARTIES SUBMISSION AND OTHER MATTERS

[79] I do not think it appropriate to make any formal determination in respect of the following matters for the reasons I explain.

1. The assessment by Nurse Traill and whether or not Mr Bell should have been referred to a psychiatrist

[80] The purpose of Nurse Traill's assessment was essentially to ascertain whether or not Mr Bell had any ongoing suicidal ideation. While the assessment was somewhat cursory, she was aware of Dr Devine's note to the effect that Mr Bell "wanted to die" at the time she saw him. She considered it was her job to consider whether he was still at risk of such ideation. She paid heed to the verbal and non verbal signals given by her patient. Ultimately, her views coincided with the doctors who saw Mr Bell. As she put it, he had no further thoughts of "self poisoning". She too was of the opinion that he had full legal capacity. Furthermore, I find that she was aware of the procedures enabling her to contact other colleagues on duty - including, if required, the on-duty consultant psychiatrist. She stated that had she any doubts, or was unable to make up her mind about Mr Bell's state of mind she would have invoked these procedures. She readily accepted in her evidence that she did not carry out a full assessment — but maintained she had sufficient information to determine whether or not Mr Bell had any suicidal ideation. In the absence of any additional, or expert evidence I am

not prepared to make any finding criticising Nurse Traill. Nor, as I have been invited, am I able on the evidence to determine that Mr Bell should have been referred to any other mental health expert. I also find it difficult to accept Mr Murdoch's submission that Mr Bell should have been kept in hospital until a full psychiatric assessment was done. If Mr Bell had capacity, then he could not have been kept in hospital against his will. If he was not at risk to himself, having thought better of what he had previously done, then it is difficult to see how and on what basis the hospital staff could make him stay. I think the hospital 'policy' of keeping Mr Bell "occupied" with cups of tea and similar diversions with a view to keeping an eye on him for as long as possible in the face of his insistence on going home, highly commendable. The more so given that the A & E Department was frantically busy at the time. I am not prepared to speculate about what might have happened if Mr Bell had been assessed by a psychiatrist given that I heard no evidence on this point.

[81] However, I note that (1) Nurse Traill appeared to be unaware of the A & E doctor's general policy of wanting to keep patients suffering from drug overdoses under observation for as long as possible. (2) Her understanding that Mr Bell would only have been referred to her if he had been fit for discharge. This does not fit the medical evidence I heard and (3) Mr Bell's prior psychiatric history did not appear to have been explored to any extent by Nurse Traill. During Mr Murdoch's cross examination Nurse Traill referred to Mr Bell's previous treatment at Stratheden Hospital and the nurse was asked whether his medical notes could be obtained. The availability of his notes appeared to depend on who was on duty at whatever time any request was made to that hospital. She did not request or receive them. This line of questioning was not developed to any extent, and accordingly I cannot comment further.

2. Should Mr Bell have been reported to the police by the hospital as a vulnerable or missing person

[82] In light of my finding that Mr Bell had full legal capacity at the time when he decided to leave hospital — and in particular that he knew and understood the risks of doing so, I do not think it would be appropriate on the evidence to make a finding such as that suggested above. The questions that were asked of Mr Roy, Mr Leigh- Smith and Dr Ng appeared to me to be relevant to patients who left or absconded from hospital, and who had no capacity to make that decision. I do not consider that Mr Bell falls within that category. I was not referred to any specific vulnerable adult legislation or procedures when being invited to consider this matter. On no view do I think that Mr Bell can be described as a “missing person” for the reasons I have specified.

3. Mr Bell’s Behaviour

[83] I agree with the Crown submission that if Mr Bell had refrained from consuming illegal drugs, had followed the hospital staff’s emphatic advice to remain in hospital for observation and the paramedic’s advice to return to hospital for that purpose, that he would probably not have died in police custody. However reprehensible his actions may be, he was free to decide these matters for himself. I have determined that he had full capacity to do so. I am not concerned at this Inquiry with considering the culpability of Mr Bell’s actions. I consider that notwithstanding the considerations outlined by the Procurator Fiscal, there are lessons which may be usefully learnt from Mr Bell’s death.

4. Was Mr Bell under the influence of alcohol

[84] For the reasons given by Mr Macpherson, I do not think it necessary to consider whether or not Mr Bell was under the influence of alcohol. I agree that what is significant is that the police witnesses dealing with Mr Bell had good reason to believe that he was under the influence of alcohol, or at least combination of alcohol and other substances. Mr Bell himself admitted in the CCTV footage viewed at the Inquiry, that he had taken “whisky and a couple of this of beer”. Several

witnesses spoke to him giving the appearance of being under the influence of alcohol and to there being a smell of alcohol. I accept that evidence.

5. Should Mr Basden have done more to persuade Mr Bell to return to hospital?

[85] I am not prepared to find that Mr Basden should have done anything more than he did to persuade Mr Bell to return to hospital. Mr Basden was not challenged to any great extent on this point. I have noted his evidence to the effect that he wanted Mr Bell to return to hospital and explained that if he did not do so, he would die. I accept this evidence.

6. The patient and carer form

[86] An example of the Patient and Carer Form is appended to the last pages of Crown production 12. I do not intend to add to what I have already said about this form, beyond stating that I found Mr John Anderson's evidence about its purpose helpful. I leave it to him, and to the Service to consider whether it ought as a matter of routine to be handed over to the police. That did not happen in this case — despite guidance specifying that it should. I can see advantages to having care instructions highlighted in a separate form. However, proliferation of paperwork may dilute the transmission of important information. Furthermore if the E-pacer Patient Report is to double as a patient/carer form, I should note here my agreement with Mr Murdoch's submission that it is not as clear as it might be.

7. The Police Vulnerability Assessment

[87] While I have highlighted a number of matters in respect of the vulnerability assessment carried out, I am not prepared to undertake a wholesale critique of that process, particularly as it

appears that some of the important factors relating to Mr Bell's vulnerability were noted. What was missing, as I have stressed was any real understanding of their significance.

8. The Force Medical Examiner

[88] I am not prepared to extrapolate from productions not explored in evidence details about the number of other custodies purportedly seen by a police force medical examiner on the day of Mr Bell's death. If this had been significant issue no doubt it would have been explored in evidence.

[89] I am also not prepared to make a finding about if or when a F.M.E. should have been asked to examine Mr Bell, or what any likely result might have been. I heard limited evidence on such matters. For example, Dr Hiremath suggested that there was no impediment to Mr Bell being seen by a F.M.E. had one been called. She was also of the view that an ambulance crew assessment met the guidance she was responsible for drafting in Production 12 (see Footnote 5) and that at the stage of admission into custody, no F.M.E examination would be required. To be fair to Dr Hiremath, her answer to a line of questioning that someone with Mr Bell's risk assessment profile might have been considered for medical referral was understandably cautious given that she was primarily a witness as to "procedures" not fact. I do not think her evidence, as a whole, would justify a finding that a F.M.E. should have been called in this case. It may well have been the case that had a F.M.E been summoned more searching questions and detailed answers might have been asked of, and responded to by, Mr Bell and a more accurate history obtained. I am not prepared to speculate on such matters given the restricted evidence heard at the Inquiry on this matter. For the same reasons I am not prepared to assert, as requested, that JJ custodies should be seen by a Force Medical Examiner. The implications of any such recommendation were not examined — let alone the necessity for such a requirement.

[90] It is clear from what I have already said that if Mr Bell had been properly observed, the deterioration in his condition would probably have been noticed and medical assistance summoned.

9. Inter Agency Information Transfer/Collation of Hospital Information

[91] I have also been invited to make general and specific findings about having a system in place to ensure that all the relevant information concerning Mr Bell was gathered, preserved, analysed and exchanged appropriately between agencies. Mr Murdoch and Mr Thompson went so far as to suggest that I should make a finding that a “hospital information base” should be set up to inform other agencies about patient’s details. I have made general and specific comments about certain aspects of these matters above and of course I agree wholeheartedly with the joint submission from Messrs Watson and Vaughan that it was important in the circumstances of this Inquiry for appropriate information should be obtained, recorded and exchanged. I also hope that this case would encourage all the relevant organisations — not simply the police - to, at least, review their practices. However I am not prepared to go further than I already have in dealing with these matters. I specifically hold that I am not in a position to make detailed recommendations about what the Scottish Ambulance Service should have recorded in the E-pacer Patient Report (as outlined on page 2 of the submissions made on behalf of Constables Scott, Barton and McIntyre) — except insofar as specified elsewhere in the determination.

[92] Furthermore, I am not convinced that agencies were not prepared to share information. On the evidence before me, the hospital did respond to the police inquiry about Mr Bell’s hospital admittance. (Whether they did so fully is another matter) I heard no evidence about what different system if any should be in place, what the term appropriate information” should encompass, what the cost implications of any such system are, whether any such system is feasible and what patient confidentiality issues are raised. The last point I suspect raises several complex issues.

10. Changes since Mr Bell’s death

[93] Mr MacPherson indicated in his closing submission that more robust steps are apparently now being taken to supervise custody staff. I heard no evidence about such matters and cannot therefore comment further.

[94] I also heard evidence that since Mr Bell's death, the observation cells in Dunfermline Police Station have increased fivefold. I record this lest anyone reading this determination should think it surprising that such an obvious matter is not referred to. I heard no evidence however relating to the number of cells which should have been provided at the relevant time. Accordingly it would be inappropriate to say anything further.

11. The Protocol and The National Memorandum of Understanding

[95] Whether there is an inconsistency between the provisions of the protocol agreed between Fife Constabulary and the Scottish Ambulance Service (Crown production no. ii) and the National Memorandum of Understanding between the Scottish Ambulance Service and the Association of Chief Police Officers of Scotland (Crown production no. 42) is, as Mr Paterson put it, of limited bearing on the issues on this Inquiry". What I do think relevant is that both services should have a clear understanding of what the other's purpose and function is — particularly in respect of persons who are drunk and incapable. Sentences such as "The (ambulance service) service will not assess a drunk and incapable person in police custody solely for the purpose of certifying fitness for detention and is not routinely responsible for the operation or management of any refuge or place of safety"¹¹ raise questions in my mind about what the "other purposes" of the "certification" are arid, the circumstances in which that service might accept responsibility for places of safety. Whilst I can readily accept that it is important for operational matters to be defined clearly, I do not think that such "management speak" should encroach on working practice to the extent it may hinder rather than assist organisations in properly understanding and fulfilling their respective functions.

¹¹ See page 4 paragraph 6.2 of the National Memorandum

10. CONCLUSION

I thank all parties to the Inquiry for their assistance to the Court — including their timeous preparation of their closing submission, which was very much appreciated. I can well understand that the Inquiry must have caused Mr Bell's family great upset and I wish to record the Court's sympathy to them.