DETERMINATION BY EDWARD F BOWEN QC INTO THE DEATH OF PC LEWIS FULTON

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND

SUDDEN DEATHS

INQUIRY (SCOTLAND)

ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by EDWARD F BOWEN QC, Sheriff Principal of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at GLASGOW on the Twenty third day of September Two Thousand and Two and subsequent days into the death of PC LEWIS FULTON

GLASGOW, 31 January 2003.

The Sheriff Principal, having considered all the evidence adduced, DETERMINES:

in terms of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 Section 6(1), (a) that on 17 June 1994 Lewis Fulton, aged 28 years, a police constable of Strathclyde Police acting in the course of his duty in Norfolk Street, Glasgow was stabbed in the right chest by Philip Anthony Robert McFadden, aged 18 years, who resided at Flat 2/3, 6 Wellcroft Place, Glasgow and later died in the Victoria Infirmary, Glasgow 1835 hours on said date; (b) that the cause of death was a massive internal haemorrhage due to a stab wound to the trunk.

General Observations

1.1 This is an Inquiry into the tragic circumstances surrounding the death of a police officer in June 1994. The Inquiry commenced on 23 September 2002 and evidence was led initially over a period of five days. Evidence was further led on 11 and 12 November 2002. At total of 43 witnesses gave evidence, 26 of these being serving or retired police officers. Thereafter parties' representatives lodged written submissions, the Inquiry effectively closing on 22 November 2002.

1.2 As a result of the incident at which PC Fulton was fatally injured, Philip McFadden appeared before the High Court of Justiciary on 30 September 1994 on a charge of murder. Having heard evidence from forensic psychiatrists the court found that Philip McFadden was insane and unfit to pled and he was ordered to be detained in the State Hospital, Carstairs in terms of Section 174(3) of the Criminal Procedure (Scotland) Act 1975. Following an improvement in his condition Philip McFadden again appeared before the High Court on 5 December 2000 on nine charges relating to incidents on 8 April and 17 June 1994 including the murder of PC Fulton. On this occasion, in respect of that charge of murder, he was found to be have been insane at the time. He was ordered to be detained in the State Hospital in terms of Section 57(2) of the 1975 Act, where he presently remains.

1.3 I narrate that history because I do not regard it as satisfactory that this Inquiry was held over eight years after the event giving rise to it took place. I can see that, in accordance with practice, no Inquiry could have been contemplated before September 1994, and there might have been a possibility of McFadden's recovery and reappearance in a criminal court which delayed a decision to proceed with an Inquiry immediately thereafter. However, to have left that decision until the end of 2001 was from my perspective inexplicable. The result has been an expensive investigation serving, in my judgement, very little public benefit. There have been substantial changes in the training and equipping of police officers during the intervening period, not least in respect of the routine provision of body armour and CS Incapacitant Spray. It is self-evident that the availability of such equipment would have materially reduced the risk of injury to officers dealing with McFadden on 17 June 1994. There have also been improvements in training in self-defence and in dealing with the mentally disturbed. These are the critical matters for an Inquiry into an incident of this nature. Much was made of what might be described as the operational handling of the incident, but the fact remains - as the recent tragedy in Manchester demonstrates - that at any moment a police officer may find him or herself faced with a violent and unstable individual, in which situation personal training and the immediate availability of effective equipment are the factors which determine the outcome of the confrontation. In respect that deficiencies in training and equipment have been addressed by Strathclyde Police, it appears to me that the purpose of the Inquiry has been largely superseded by events. Further, it is to be observed that I am required by Section 6(1) of the 1976 Act to determine whether there are reasonable precautions whereby the death might have been avoided. What would be reasonable can only be judged by contemporary standards and that raises a difficulty. No evidence was led, for example, as to whether it would have been reasonable in June 1994 to have equipped every operational officer in Strathclyde Police with body armour, although the evidence was that it was introduced shortly thereafter. Whilst there was clear evidence as to precautions which might have avoided PC Fulton's death I am not prepared to make any specific findings as to which of them would have been reasonable.

1.4 Before turning to the factual findings which I consider it appropriate to make, there is one further matter of general importance on which I wish to comment. As I have indicated this Inquiry occupied seven days of court time, substantial police time and the expense of representation of six parties, most of it borne by the public purse. Having said that it is fair to say that based on current procedures it could not have been concluded much more swiftly and those involved are to be commended for that. Areas of formal evidence were dealt with by minutes of agreement; there was little in the way of the type of aimless re-examination of witnesses which often bedevils Fatal Accident Inquires; problems of attendance of witnesses which disrupt the running of criminal courts were not encountered, and final submissions were made in writing. Nevertheless it appears to me that the facts of the situation were largely undisputed and, at the end of the day, the areas of controversy confined. I am conscious that in this court many Fatal Accident Inquiries now run for periods which would never have been contemplated ten or twenty years ago. Much time is expended without any clear purpose and on evidence which is often repetitive. Although this Inquiry is by no means a bad example it could have been shortened if, for example, a detailed statement of facts had been set out by the Crown at the outset with an invitation to interested parties to indicate areas of challenge and matters which required detailed examination. In my view the time has come for a re-examination of procedures under the 1976 Act with a view to establishing a system which serves both the public interest and the concerns of grieving relatives. Such a system would involve at the very least a preliminary hearing at which the uncontested facts could be determined, areas of controversy identified, and a programme set out for the attendance of witnesses.

1.5 With these preliminary observations I now turn to the facts which I hold are relevant to the circumstances of the death of PC Fulton in terms of Section 6(1)(e) of the 1976 Act.

Findings in Fact:

2.1 Schizophrenia is a condition which affects four per cent of the population at some time in their lives. Philip McFadden was diagnosed as suffering from a schizophrenic disorder no later than October 1991. Following signs of the onset of a psychotic illness he was admitted to the adolescent unit of Gartnavel Royal Hospital where he was treated as an in-patient from September 1990 until May 1991. He was treated with varying types of medication and the "florid" symptoms of his condition (mainly visual and auditory hallucinations) subsided, leaving negative symptoms in the form of lethargy and lack of motivation. In March 1991 his medication was changed to a depot preparation (ie an injection which can have effect for more than a few days). At the time of his discharge he was receiving depot injections fortnightly, and this continued on an out-patient basis until about July 1993. The purpose of that medication was to alleviate the negative symptoms of his condition, and to reduce the danger of recurrence of the florid symptoms. When visited at home by a nurse therapist on 16 July 1993 he refused medication, and similarly refused medication on 20 July 1993. Continuous attempts were made by the Adolescent Psychiatry Service to persuade him to resume medication by way of letters, appointment arrangements and home visits. He ceased to fall within the ambit of responsibility of that Service on reaching the age of 18. He was seen at his GP's surgery on 6 December 1993 and 29 March 1994. On each occasion he was spoken to by the nurse practitioner who attempted to persuade him to resume his medication. Mr McFadden's attitude was that he was feeling better and did not require it.

2.2 On the evening of 8 April 1994 Philip McFadden was arrested in Paisley Road West by two officers of Strathclyde Police. He had formed part of a group of youths who had been drinking and were dispersed. McFadden refused to move. He approached the officers brandishing a bottle, swore at them, referred to them as "authority" and asked if they "believed in reincarnation". He was conveyed to Orkney Street Police Station at 2115 hours and was released at 2345 hours. The matter was reported to the Procurator Fiscal. It was not the subject of proceedings until it was contained in the Indictment which included the charge of murder brought before the High Court in December 2000.

2.3 Other than said incident of 8 April 1994 there was nothing in the behaviour or medical history of Philip McFadden which indicated a propensity to violence, or of an aggressive attitude which might lead to violence prior to 17 June 1994.

2.4 As at 17 June 1994 Philip McFadden was living with his mother, brother, two sisters and the infant daughter of one of them at Flat 2/3, 6 Wellcroft Place, Glasgow. They had been allocated that house following a fire which took place in their normal home at 44 Maclean Square, Kinning Park, about two months previously. For some days prior to 17 June Philip McFadden had not been sleeping well and had been restless. He spent the night of 16/17 June in the house in the company of a friend and had little or no sleep. In the course of the morning his behaviour became erratic and he began to display some of the "florid" symptoms of schizophrenia. He said that someone had cut off his hands. He pointed to scaffolding which had been erected on a building opposite the flat and said that people had been crucified on it. He said that he was to be next. He made threats to harm his brother Bernard who had left to go to work. He eventually armed himself with a large kitchen knife. At that stage his mother left the house, as she was becoming increasingly concerned about his behaviour. After making phone calls to Gartnavel Hospital and to the GP practice Mrs McFadden went to the surgery where she saw Mrs Fitch, the nurse practitioner. Mrs Fitch caused the practice administrator Avril Houston to telephone Dr Russell GP, the senior partner in the practice. She relayed to Dr Russell that Philip McFadden intended to attack his brother and was armed with a 7" knife. Dr Russell said that he could not go into that situation and that it would be necessary to call the police. Avril Houston telephoned Aitkenhead Police Office.

2.5 That telephone call was received by a communications assistant Sharyn Gray. She recorded the information on an incident form which was passed to the Divisional Controller PC Moran who entered it onto the Command and Control Machine at 1517 hours. Sharyn Gray dispatched PCs Pryde and Gordon to the locus at 1520 in a police vehicle FM3. She told them that a doctor would be in attendance.

2.6 PCs Pryde and Gordon arrived at the locus in approximately two minutes. After waiting for a brief time in a car park they went to the door of 2/3, 6 Wellcourt, Croft Place, which was answered by one of Philip McFadden's sisters. The second sister was also present. Almost immediately Philip McFadden appeared in the hallway carrying a knife. Both sisters appeared more concerned for the well being of the police officers than they did for

themselves. Philip McFadden moved down the hallway shouting "I'm going to kill you". Both officers withdrew, returned to their vehicle and radioed both the Divisional Control Room at Aitkenhead Road and Force Control at Pitt Street. The Command and Control Incident log recalls a report at 1528:

"Male at locus unstable has threatened police with a very large knife."

and at 1531:

"Support Unit and Dog Vehicle requested".

In the meantime the McFadden sisters withdrew from the house along with the child and were placed in the rear of the police vehicle FM3.

2.7 A second police vehicle containing Police Inspector McKenzie, Sergeant Blair and PCs Fernie and McInnes attended at the locus from Gorbals Police Station. These officers were informed by PCs Pryde and Gordon that there was a man in the house at 6 Wellcroft Place armed with a knife. Before further action could be taken telephone calls were received by the police that a man with a knife was in the street near the locus. The Command and Control Log reveals "Male now apparently out of house and into Cumberland Street" at 1538. The six officers went in search of him and McFadden was seen in Bridge Street moving towards the City Centre. The officers moved up behind him and Sergeant Blair ran past him on the carriageway. McFadden pursued Sergeant Blair to the junction of Bridge Street and Oxford Street where Sergeant Blair fell whereupon McFadden lashed out with a knife and struck him on the arm. This incident was recorded at 1545. McFadden then walked back down Bridge Street and into Norfolk Street where he attempted to kick in a shuttered door. He moved on to the last shop in the block, Clyde Superstores, where he again kicked at the door and lashed at it with a knife. He had been followed to that position by at least six police officers on foot, namely PI McKenzie, Sergeant Blair, PCs Fernie and McInnes, PC Gordon who had exited from the vehicle FM 3 and PC Fulton who had joined them. Police Constable Mitchell who attended from Craigie Street was also following in a panda car.

2.8 In response to a call for assistance PCs Lawson and McKenzie who were on mobile patrol in the area of Battlefield drove to the locus. They saw McFadden brandishing the knife at the group of officers. PC McKenzie drove his car onto the footway an attempted to trap McFadden in the shop doorway. McFadden began to strike the driver's window with the knife, forced open the door car and attempted to strike PC McKenzie with it. PC McKenzie managed to disengage from McFadden by reversing the car and a number of officers including Sergeant Blair and PCs Fernie and Fulton began to strike McFadden with their batons in an effort to disarm him. In the course of the melee which took place in the shop doorway of Clyde Superstores McFadden struck PC Fulton a blow to the body with the knife. This was recorded as having occurred at 1547.

2.9 McFadden then ran from the shop doorway pursued by PC Fernie. They were struck by a police vehicle moving slowly and knocked to the ground. McFadden was overpowered and detained.

2.10 PC Fulton was taken to the Victoria Infirmary in Glasgow where despite intensive attempts at resuscitation he died in the operating theatre of that hospital at approximately 1835 hours on 17 June 1994. A post-mortem examination was conducted with the mortuary of Gartnavel General Hospital, Glasgow on 18 June 1994. It revealed that death was due to massive haemorrhage related to a single stab wound to the trunk which has passed into the right chest cavity, penetrated the diaphragm and cut into the liver, and had then passed into the pericardial sac and penetrated the inferior vena cava (the main vein of the body). The cause of death was certified as 1(a) stab wound to the trunk.

2.11 All officers present at the incident on 17 June 1994 carried short wooden batons which where the only items in general issue to officers of Strathclyde Police for personal protection at that time. They had no items of protective clothing. Since that time officers have been issued with PR24 side handled batons, CS Incapacitant Spray Canisters and stab resistant body armour. The availability and use of any of these items might have avoided the death of PC Fulton. Since the incident officers have also been issued with rigid handcuffs which can be snapped onto the wrists of a person resisting arrest. It is unlikely that the use of such handcuffs would have been affective in restraining Philip McFadden.

2.12 At the date of the incident a number of full-length riot shields were held at Divisional Headquarters at Aitkenhead Road Police Station. These shields were placed in a police van with a view to being taken to Norfolk Street but the incident was over before they could be dispatched. Said shields might have afforded protection to the officers in dealing with Philip McFadden but they were cumbersome and would have been difficult to use in trying to contain him in a confined space. Since the death of PC Fulton smaller lighter shields are carried as a matter of routine in police vehicles. The use of lighter shields might have avoided the death of PC Fulton.

2.13 The Support Unit of Strathclyde Police was based at Springburn Police Office. It held amongst its equipment "public order gear" which compromised limb protectors for arms and legs, special gloves, helmets with visors and protective shields. This equipment was also referred to as "angry man kit". It did not at the material time include body protection. On the afternoon of 17 June 1994 the Officers of the Support Unit were attending a debrief at the Police Federation Offices in Merrylee Road. The equipment was kept at Springburn Police Office. Whilst at Merrylee Road the Support Unit Officers were instructed to attend at 6 Wellcroft Place. They reported that their angry man equipment was not available and steps were taken to take that to the locus from Springburn Police Officer. The Officers of the Support Unit were advised en route to the locus that the incident was over and were told to stand down.

2.14 At 1542 hours an Armed Response Unit was resourced and vehicle FM10 was recorded as proceeding to the locus. That vehicle contained two officers armed with Smith

and Wesson revolvers and equipped with ballistic armour and ballistic shields. The vehicle was dispatched on the basis that the officers had access to that armour and those shields. The officers in the vehicle were listening to the development of the incident on the vehicle's radio. On hearing that a man armed with a knife was threatening a group of police officers in a public place they sought authority to draw firearms. That authority was refused by Mr Welsh the Duty Assistant Chief Constable. The vehicle arrived at the locus at 1548 by which time PC Fulton had been injured and McFadden detained.

2.15 At the date of the incident all officers involved had received rudimentary training in the use of truncheon and handcuffs, and in self-defence and resistant techniques. In July 1994 as a direct result of the death of PC Fulton a programme of training involving a five day course in self-defence for all uniformed officers of the rank of Inspector and below was instituted throughout Strathclyde Police. The programme was implemented in October of that year. As well as self-defence techniques the training involved basic instruction in the identification of persons suffering from mental illness in particular schizophrenia and how to deal with them. That programme was subsequently developed and extensive training in mental health awareness was rolled out through Divisions in Strathclyde Police from 1996. Re-qualification in these programmes is now a matter of routine.

2.16 The deployment of police dogs is, and remains, a matter for Force Control. In response to the request from Divisional Control at 1531 for a Dog Vehicle Force Control requested the attendance of dog vehicle VM22 which was the only dog vehicle on operational duty at that time. That vehicle was in Ayr with an estimated return time to Glasgow of 40 minutes. No other request for the attendance of a dog vehicle or dog handler was made in the course of the incident.

2.17 The Police Dog Training Branch was situated at Pollok Park, Glasgow approximately 10 minutes from the locus. At least one police dog and handler were there on the afternoon of 17 June. It would have been possible for Force Control to have made contact by telephone with the Training Branch. Two dog handlers and dogs were present at the Police Training Centre in Oxford Street, Glasgow a very short distance from the locus. They were taking part in an exercise in support of the Tactical Firearms Unit. Their presence there was not known to Force Control but contact with them could have been made by means of telephone via the Training Centre in Pollok. A dog handler could have been detached from training and sent to the locus.

2.18 At the time of the deployment of VM22 Philip McFadden was still in the house at 6 Wellcroft Place. No further attempt to deploy a dog was made by force control between the sighting of McFadden in the street at 1538 and the fatal assault on PC Fulton at 1547 due to the speed at which events unfolded.

2.19 Police dogs are trained to deal with individuals armed with knifes. The deployment of a police dog would have been appropriate to deal with McFadden, either in the house or in the street, and this might have avoided the death of PC Fulton.

Comment

3.1 I commence by dealing with what might be described loosely as the "medical" aspects of this Inquiry. These concern the adequacy of treatment provided to Philip McFadden prior to June 1994 with specific reference to attempts to convince him of the need to take medication, and the involvement of Dr Russell in the events of 17 June.

3.2 No party to the Inquiry criticised the standard of care provided to McFadden by medical or psychiatric services in the relevant period. The medical history is well documented and was investigated in depth by the Mental Welfare Commission for Scotland following a reference by the Secretary of State to them on 27 October 1994. It is sufficient to quote from the summary of findings of that report (production no 17) at para 9.11:

"Philip McFadden developed a schizophrenic illness at the age of 14 and received very appropriate treatment from the Adolescent Psychiatry Service in Glasgow, including follow up treatment over a period of two years and assertive attempts to keep him in treatment when he opted out of it. He and his mother also received considerable support from their general nurse practitioner. At no point in his earlier psychiatric care were compulsory measures used or necessary. He was also not known to have acted in relation to his delusions in any dangerous manner".

The report continues:

"Over about two months prior to June 1994 he developed a vague and increasing sense of threat to himself. In a few weeks before 17 June, his thinking began to become more disordered and he became acutely and severely disturbed on the day before 17 June. This was not known to anybody apart from his family, and perhaps some friends. Philip McFadden was not a long stay hospital patient 'dumped' in the community".

3.3 The evidence led before the present Inquiry, from Dr Dyer of the Mental Welfare Commission and Dr McCabe a Consultant Adolescent Psychiatrist fully confirms these views. The last sentence above quoted from the MHW Report is fully justified. Philip McFadden was not, on 17 June 1994, an individual who ought to have been the subject of compulsory hospital care. He was a young man suffering from an unfortunate illness which was subject to a natural deterioration. There was an indication that this deterioration may have been contributed to by some form of drug taking but there was nothing to suggest that this amounted to any form of addiction. Most significantly, there was nothing in his history to suggest that he had violent tendencies which would cause him to be a threat either to himself or to others.

3.4 In that situation the risk of not continuing with medication was that Philip McFadden would be unable to achieve his full potential in terms of education, employment and the formation of personal relationships. There was no reason to infer a risk that he would suddenly resort to irrational violence.

3.5 In the body of their findings the Mental Welfare Commission noted that Philip McFadden had been treated with medication for more than two years following his discharge from inpatient psychiatric care, and that this accorded with acknowledged good practice in the treatment of schizophrenia. The difficulty which occurred thereafter is a common one. Even when medication appears to have been effective a recurrence of the symptoms of the illness is likely, although that might not happen for several years. The problem is that the patient feels well, sees no need to continue with any form of medication, and will have difficulty in accepting the continued existence of a serious illness. In that situation it is difficult to persuade the patient to continue to accept medication. That was the position of Philip McFadden which prevailed immediately before 17 June 1994. It falls to be emphasised that there was no cause prior to that date for requiring his compulsory detention under the relevant Mental Welfare provisions.

3.6 Proposals contained in a Mental Health (Scotland) Bill presently at an advanced draft stage contain a procedure for compulsory treatment orders for persons suffering from mental disorder without the need to resort to detention for that purpose. The symptoms displayed by Philip McFadden immediately prior to 17 June 1994 would not, however, have met the criteria for compulsory treatment even if the legislative proposals had been in effect. It is not possible to legislate for the compulsory treatment of someone with a schizophrenic disorder whose only symptoms are lethargy and lack of motivation.

3.7 There is one matter in the Mental Welfare Commission Report with which I respectfully disagree. Paragraph 9.14 criticises Dr Russell in relation to his actings on 17 June 1994, stating that "it would have been appropriate" for him to have attended at 6 Wellcroft Place with the protection and assistance of the police, or should at least "have attempted to acquire more knowledge about Philip" by consulting Mrs Fitch or his partner Dr McKeave, or by reading the case notes. This criticism gave rise to consideration by the Medical Service Committee of Greater Glasgow Health Board as to whether Dr Russell was in breach of his Service Agreement. The Committee took the view that Dr Russell had acted appropriately and I agree with that conclusion.

3.8 The matter is not strictly relevant to the Inquiry since it is hard to see, and was not suggested, that Dr Russell's attendance at the locus along with the police might have prevented PC Fulton's death. It is right to record, however, that all the evidence suggested that Dr Russell did not act "inappropriately". Other medical witnesses who gave evidence considered that if there was a danger of assault by a patient a doctor was entitled to have the situation "contained" by the police before entering it. That position was acknowledged on behalf of the police by Superintendent McKie, Superintendent in Community Safety with responsibility for social inclusion. Proper practice is set out in a document issued by the Scottish Executive Health Department headed "Roles and Responsibilities of General Practitioners and Police dealing with potentially violent mentally disordered persons in the

community" issued in December 1999. In relation to incidents where the police suspect that mental disorder is a contributory factor to violent conduct the document contains the following paragraph under the heading "GP Attendance":

"If contacted the GP should consider whether he can best assist the police in assessing the medical aspects of the situation by attending the incident in person in a supportive role. It may not, however, be practical for a GP to attend an incident in person if it occurs outside his practice area. In these circumstances, good practice would suggest that the GP should, if possible, remain available by telephone to assist the police or any other doctor called to the incident. Guidelines by the General Practitioners' Committee of the BMA in Scotland, on dealing with persons with severe mental illness, indicate that, where there is information suggesting that an offensive weapon is in use or there is a significant threat of violence, a GP is entitled to await resolution of the incident by the police before attending the scene. Police procedures should ensure that, when it is appropriate and practical, essential personnel such as a GP or other doctor, can attend a prolonged incident safely in a support capacity".

There is nothing that I can usefully add to the terms of that paragraph.

3.9 Finally, on this aspect I observe that Superintendent McKie confirmed to the Inquiry that arrangements had been put in place to improve police access to information relating to the history of persons with mental disorders should this be necessary with a view to controlling a potentially violent situation.

Comment - Police Resources

4.1 I have made factual findings at paragraphs 2.11 and 2.12 concerning protective clothing, side-handled batons, CS incapacitant spray and light weight shields. I can make no finding as to whether it would have been "reasonable" for any of these items to have been available in June 1994. I am not aware as to the extent to which such items had been tested or were available for purchase and issue. The evidence regarding lack of training in self-defence techniques I found surprising. I would have expected a better level of training of operational police officers in 1994. PC Fulton and his colleagues would probably have been better able to deal with McFadden if they had received training in such techniques; whether that might avoided his death is impossible to say. I am pleased to note that self-defence training is now much more advanced and extensive.

4.2 There is no doubt that the use of a police dog was a reasonable resource, which if deployed, might have avoided PC Fulton's death. A dog vehicle was immediately resourced after PCs Pryde and Gordon had reported being threatened when they called at 6 Wellcroft Place. That was an appropriate step. The difficulty was that the only operational dog vehicle was in Ayr, at least 40 minutes drive away, a fact which was known at 1534 hours. The question which arises is whether it would have been reasonable to secure the attendance of another dog handler. Inspector Caie the Force Controller who had responsibility for

deployment of dogs accepted in cross-examination that it would have been both possible and "reasonable" to have requested the attendance of a dog handler by telephoning the Dog Training Centre before the fatal stabbing at 1547 hours. In theory at least it follows that "the deployment of a police dog was a reasonable precaution whereby PC Fulton's death might have been avoided". That conclusion is, however, subject to two qualifications. The first is that the judgement that a request for an alternative dog would have been "reasonable" is made with the benefit of hindsight. In the 13 minutes between 1534 and 1547 much was happening at Force Control and any criticism for failing to resource a second dog would in my view be a harsh one. Secondly, to have resourced a dog from Oxford Street which was admittedly very close to the locus would have required one telephone call to the Pollok Training Centre to establish that a dog was at Oxford Street, followed by a second call there, followed by the withdrawal of an officer from training and deployment to the locus. It must be very doubtful whether that could have been achieved in time to have prevented the fatal assault.

4.3 That in turn raises an issue of communication with dog handlers who are not on operational duty but who may nevertheless be available for fairly rapid deployment when, for example, they are attending training courses. Although the issue was not examined in detail there was evidence that dog handlers attending courses do not carry personal radios although it was said that there was "no particular reason" why they should not. I make no specific recommendation in this regard but it does appear to me that the system of communication with dog handlers is one which ought to be re-examined.

4.4 In paragraph 2.13 I have made findings in relation to the attendance of the Armed Response Unit. It was appropriate for this vehicle to be sent to the locus in view of the fact that it contained ballistic armour and shields, albeit these items are not intended for the deflection of sharp weapons. That vehicle arrived at the scene as quickly as it could allowing for the state of the traffic. It does not appear to me that the issue of whether it was appropriate to draw firearms was one which could have been determined properly before the armed response unit arrived and the officers of it were able to assess the situation. I am quite satisfied that the decision of A C C Welsh to deny authority to draw firearms in advance of that stage was correct. The use of firearms in Norfolk Street in the vicinity of the door of a shop which contained members of the public would have been dangerous, and I am inclined to the view that the firearms officers themselves would not have considered it appropriate once they had been in position.

Comment - Communication and Control

5.1 In their written submissions agents for both the family of PC Fulton and for the family of Philip McFadden were critical of certain of the communications and control aspects of the police operation. It was suggested that the officers who first attended at the McFadden house were not provided with "sufficient" information, and that PI McKenzie the Senior Officer "on the ground" was unable to communicate with and control the actions officers attending who were left to act on their own initiative.

5.2 In reaching any view on the first of these matters there is a difficulty in determining exactly what information was provided to the police before PCs Pryde and Gordon were despatched to the locus. The command and control log has, as its opening entry: "Son with a knife stating that he will stab his brother on his return home. Doctor will meet police at locus". The "reporter" of that incident is specified as Dr Russell. There is no mention of mental instability until an entry at 1535 which reads: "Medical history of male is that he has had a previous nervous breakdown". It is reasonable to conclude that this information was provided by the McFadden family.

5.3 There is no doubt that the first report to the police was made by Avril Houston, Dr Russell's Practice Manager, rather than by Dr Russell himself. Avril Houston said that she told the police that: "We had a problem in that a young 17 or 18 year old boy had a 7" bladed knife in the house" and that his niece was there who was a young baby. She said that she was asked if the doctor was going in and said that the doctor was not going in until the man was disarmed and that it was safe for him to do so. She also said that she was asked if the man had a known mental history and related that whilst she was not sure of the diagnosis she thought that he could be schizophrenic. Sharyn Gray who received the call accepted that something might have been said about the boy's state of health. She, however, was emphatic that she was told that "someone from the doctor's" would be attending, and that was the reason for the entry in the log. It also provided the basis on which PCs Pryde and Gordon attended.

5.4 I have no doubt that Avril Houston and Sharyn Gray were endeavouring to assist the court and were recounting matters to the best of their respective recollections. If Sharyn Gray misunderstood the position relating to the attendance of a doctor that is unfortunate but I do not think that it made any difference to the events which unfolded. Constables Pryde and Gordon did not wait long for the attendance of a doctor. If he had been there it is not likely that he would have entered the house ahead of them. The officers appeared to have approached their task fairly diplomatically. It is difficult to conclude that they would have gone about the initial investigation any differently had they known that Philip McFadden had a history of schizophrenia. I am entirely unpersuaded that this relatively minor breakdown in communication made any difference to the manner in which the incident was handled.

5.5 Issues were raised as to the police handling of the incident from the point at which Constable Gordon were confronted by McFadden in the hallway of 6 Wellcroft Place. It is easy to accept with the benefit of hindsight that the situation might have been handled differently and more effectively, for example, by taking steps to secure the house and prevent McFadden from leaving. One must, however, have regard to the information which was available to the police and the speed at which events evolved. The police were summoned, and responded rapidly, to a request to attend at what was on the face of it a domestic incident. There was no reason to anticipate that McFadden would leave the house and the fact that he did so, and proceeded to wander the streets carrying a large knife, was not reasonably foreseeable. Only nine minutes elapsed between the point when he was seen in the street and the fatal stabbing of PC Fulton. He was under observation by police officers for only six minutes and was as a matter of fact arrested very quickly. I am not prepared to hold that in that space of time there was a great deal that could be done by way

of strategic control. The situation was very much one for the exercise of initiative by individual officers on the ground.

5.6 In the exercise of that initiative PC Fulton courageously and unselflessly tackled an armed and dangerous man. In so doing he gave his life in the service of the community. One can only express admiration for the dedication shown by him, and by the other officers present on this occasion. I am satisfied that the level of equipment and training now available, much of which was put in place as a direct result of this incident, makes the repetition of a fatality in this sort of episode much less likely. The final witness at the Inquiry Superintendent McKie was able to confirm that better equipment and tactical training has in recent years enabled officers, when faced with very violent people, to deal with the situation safely.