2010 FAI 14

S H E R I F F 'S D E T E R M I N A T I O N

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

INTO THE DEATH OF
LESLIE JOHN MITCHELL

Held at AIRDRIE SHERIFF COURT
On
18, 19, 20, 21, 22 and 29 January 2010
and 07 February 2010

SHERIFF'S DETERMINATION

AIRDRIE: 25 MARCH 2010

NOTE

The Procurator Fiscal was represented by Mrs Jacqueline McGarrity, Procurator Fiscal Depute Hamilton, the relatives by Mr Alisdair Thomson of Carr & Company, solicitors, and the Chief Constable of Strathclyde Police by Miss Asma Ali, solicitor in the Legal Services Department at Police Headquarters, Glasgow.

Joint Minutes of Agreement were signed by all parties agreeing that a number of facts were uncontroversial and, in addition, all parties agreed that certain

witnesses' evidence could be admitted by affidavit in terms of Rule 10 of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977.

Mrs McGarrity put forward a list of forty-nine witnesses and in the course of the case a fiftieth witness, Alexander Gordon, was substituted for one of the witnesses on the list who was unable to attend. From the list which she submitted, twelve were not called because their evidence was either covered fully by other evidence which the inquiry heard or alternatively was covered by one of the Minutes of Agreement. In all cases the decision not to call the witnesses was made with the agreement of representatives both of the relatives and of the Chief Constable.

Affidavit evidence was received from witness numbers:-

1 Sylvia Redman
2 Roslyn Douglas
3 James Gallagher
4 Alistair McLean
5 Linsey McNulty
7 Jim Pringle
8 James Mitchell
9 Sarah Carrick
11 Anne Hendry
47 May Walker-Love
48 Martin Fairley

The Court heard evidence from witness numbers:-

6 Andrew McCarthy
10 Anna Hudson

12 Michael Moore

15 Karen Burns

17 Kenneth Fitzpatrick

18 George Clark

20 Zulfiqar Raja Haider

21 Graham Stronach

23 Michelle Herron

25 Aileen Grey

26 Paul McCleave

27 Robert Russell

28 Police Constable Brian MacDonald

29 Police Constable Paula Laybourne

30 Police Constable Douglas Stevenson

31 Police Constable Stewart Walton

32 Police Sergeant James Brown

33 Michael Docherty

35 Police Constable Pauline Duffy

36 Police Constable William Bowman

37 Dr Neil Howie

39 Sergeant Dawn Dunnion

40 Police Constable Alan Paterson

42 Detective Inspector Ian Rule

43 Inspector Annette Morrison

44 Dr John Clark

50 Alexander Gordon

In addition, Professor Anthony Busuttil was led as a witness by the solicitor representing the relatives and spoke to a report which he had prepared.

FACTS AND CIRCUMSTANCES

1 Leslie John Mitchell (date of birth 01 May 1957) resided alone at 6A Morrison House, Burns Road, Cumbernauld. At the time of his death he was unemployed and in receipt of benefits. He was a chronic alcoholic.

2 Mr Mitchell was 5 ft. 5 ins. in height and was very overweight. He was regarded as a likeable person by his many friends.

3 On 23 December 2008 Mr Mitchell had been drinking throughout the afternoon and early evening in the Red Triangle Snooker Club and Morriarty's Public House, both in Cumbernauld.

4 During the period between approximately 1.30 pm and 6.25 pm he consumed a considerable quantity of alcohol consisting mainly of vodka and cider. He had nothing further to drink after he left Morriarty's at about 6.30 pm. At 8.45 pm his alcohol/blood reading was 345 mgs. in 100 mls of blood.

5 After leaving Morriarty's he entered the Friary, a nearby fish and chip shop at 6.47 pm where he was loud and crude towards the female staff. He was asked to leave. He did so at 6.48 pm.

6 Mr Mitchell thereafter went along St Mungo's Walk towards the Red Triangle Snooker Club. Outside the club he fell but did not strike his head or suffer any injury. A taxi was called for him and at about 6.55 pm he, with the help of a friend, Mr George Clark, entered a taxi. The cab was operated by Central Cabs, Cumbernauld and driver by Mr Zulfiqar Raja Haider.

7 Mr Haider was asked to take Mr Mitchell to Burns Road and did so. At Burns Road Mr Mitchell, who was very drunk, became abusive, aggressive and refused to pay the fare. He fell on to the ground after leaving the taxi but sustained no injury.

8 Burns Road is a cul-de-sac and Mr Haider drove his taxi to the end, made a three-point-turn and returned down the way he had come towards the main road. Mr Mitchell had in the meantime stood up and began staggering in the middle of Burns Road facing the on-coming taxi.

9 Mr Haider stopped the taxi approximately 10 ft from Mr Mitchell who was shouting abuse. He then fell backwards away from the front of the taxi and struck his head on the roadway. He remained conscious but did not get up.

10 As the result of this fall Mr Mitchell sustained a cut to the back of his head which bled. He continued to be aggressive and abusive. An ambulance was summoned by Mr Haider and by a Mrs Michelle Herron, a resident in a nearby block of flats.

11 An ambulance attended at Burns Road within six minutes. It had come from the Ambulance Station at Greenfaulds Ring Road, Cumbernauld. It was manned by Mr Paul McCleave, an Ambulance Technician, and Mr Robert Russell, a former Police Officer and Ambulance Paramedic.

12 On the evening of 23 December there were two ambulances each with two crew on duty at the Cumbernauld Ambulance Station. When a call was received the nearest ambulance available attended. If the ambulances from other stations were already occupied one of the Cumbernauld ambulances would attend whether it was in Glasgow, Airdrie or Coatbridge.

13 Mr McCleave approached Mr Mitchell but the latter was abusive and unco-operative. He was both verbally and physically aggressive and refused to give his name or address. When Mr Russell joined his colleague he received the same response and behaviour.

14 An unmarked police car with Constables Brian MacDonald and Paula Laybourne arrived at Burns Road around 7.20 pm. They were joined shortly thereafter by a marked police car with Constables Douglas Stevenson and Stewart Walton.

15 Constables MacDonald and Laybourne were shouted and sworn at by Mr Mitchell who again refused to give his name or address. He called himself "Stevie Wonder." They ultimately got him to his feet and supported him to the ambulance which Mr Mitchell and the police constables entered so that his head injury could be treated.

16 Mr Mitchell was examined by the ambulance staff who found that his injury was superficial and minimal. There was no haemotoma, no discolouration and no evidence of internal damage. The pupils of his eyes were normal, there was no leakage from either ear and he was alert and not confused. He was very drunk and unco-operative.

17 The injury to his head had a dressing applied to it. Neither of the ambulance personnel considered that Mr Mitchell needed to go to hospital. He was however advised that he should go to hospital on two occasions but he refused. Constables Laybourne and MacDonald offered to travel in the ambulance with him but Mr Mitchell persisted in stating that he was not going.

18 Mr Mitchell was, in the opinion of both officers, drunk and incapable. He was told that if he did not go to hospital they would require to arrest him because of his condition when he had nobody to look after him. Police officers had tried to find anybody amongst the bystanders who was willing to look after him but nobody came forward.

19 Ambulance personnel have no authority to take somebody to hospital against his/her will. Despite being advised to go with the ambulance to Monklands District General Hospital, Mr Mitchell persistently and emphatically refused. He was therefore arrested by Constables Laybourne and MacDonald before they removed him from the ambulance. He was handcuffed to the front and continued to struggle and be aggressive towards the officers.

20 Constables Stevenson and Walton had been principally concerned with controlling the traffic which had built up in Burns Road due to the presence of the ambulance, two taxis and two police vehicles as well as Mr Mitchell initially lying in the roadway. They had assisted in gathering information from witnesses. After Mr Mitchell was arrested they were involved with Constables Laybourne and MacDonald in discussions as to how he should be conveyed to Cumbernauld Police Office from Burns Road.

21 Initially it was proposed to obtain a Police cell van to move Mr Mitchell. There was a cell van at Cumbernauld Police Office but Constable Laybourne believed (correctly) that it was inoperable and could not be used to transport a prisoner.

22 The distance from Burns Road to Cumbernauld Police Office can be covered in a motor vehicle in a very short period. It was decided to take Mr Mitchell in the back of the marked police car. He refused to enter the police

vehicle and was placed in the car beside Constable Stevenson. Constable Laybourne drove the marked police car with Constable Walton in the front passenger seat as due to Mr Mitchell's bulk there was insufficient room for Constable Walton in the back. Mr Mitchell continued to swear and threatened to punch Constable Stevenson.

23 Constable MacDonald brought the other police car to the station once he had spoken again to the ambulance personnel and confirmed that, in their view, Mr Mitchell did not required to go to hospital.

24 Constable Laybourne drove the marked vehicle into the rear at Cumbernauld Police Office. This is the normal procedure and provides direct access to the charge bar and the cells. Mr Mitchell was removed from the car and on entering the police station was seen by Sergeant James Brown who was behind the charge bar. Because of Mr Mitchell's aggression and lack of co-operation Sergeant Brown instructed that Mr Mitchell should be handcuffed to the rear to prevent him injuring a police officer or himself.

25 Mr Mitchell continued to be abusive, unco-operative and to threaten police officers in between periods when he was calm. He lashed out at Mr Michael Docherty, a custody and security officer, who required to search him and Constable Stevenson required to assist Constables MacDonald and Laybourne in restraining him.

26 Sergeant Brown examined the injury to Mr Mitchell's head and decided that he required a medical opinion before he could be detained in a cell overnight. This was purely a precautionary measure and Sergeant Brown was aware that Mr Mitchell had been treated in an ambulance and that in the opinion of the ambulance personnel he did not require to go to hospital.

27 To obtain a medical opinion Sergeant Brown could have summoned a police casualty surgeon. Such a call could have resulted in a delay of in excess of an hour depending on what other duties or responsibilities the doctor had.

28 Sergeant Brown decided to send Mr Mitchell to Monklands District General Hospital in Airdrie for confirmation that his prisoner was medically fit to be detained.

29 He rejected the idea of calling for an ambulance as this was not an emergency. After learning that the Cumbernauld cell van was inoperative (the lock on the rear door was defective) he accepted that a cell van should come from Airdrie to transport Mr Mitchell to the hospital.

30 He rejected the possibility of Mr Mitchell being taken in the back of a police car because of his concerns for the safety of the officers who would require to be handcuffed to him. He reached that view because of Mr Mitchell's behaviour and the length of the journey from Cumbernauld to Airdrie (fifteen minutes).

31 Sergeant Brown sought access through records to certain aspects of Mr Mitchell's history including his previous detentions in police custody. There was nothing in the information available to him before Mr Mitchell left Cumbernauld to go to Monklands General Hospital which should have given him cause for concern.

32 Strathclyde Police Operating Procedures contains a large section on "Prisoners' Custody, Care and Welfare," (production no 7). This is continually

reviewed and revised. Sergeant Brown followed the procedures recommended and his decisions and actions were based on its terms.

33 The Police cell van which came from Airdrie was driven by Constable Pauline Duffy who was accompanied by Constable William Bowman. When they arrived at Cumbernauld Mr Mitchell was taken from the charge bar area where he had remained beside Constables Laybourne and MacDonald. These officers took him out in to the back yard where the back doors of the van were opened by Constable Duffy.

34 There are different sizes of police cell vans and the van at Cumbernauld was larger than that which came from Airdrie. The Airdrie van (Reg No SF04 FGD) was one of a number of similar vans used by Strathclyde Police. It had two rows of seats at the front which could be entered through front or rear doors on both sides. Behind the rear seats were two police riot shields made of a Perspex material. The front portion of the van was separated from the rear by a number of bars which allowed anybody in the front to hear and communicate with a prisoner in the rear or vice versa. On either side of the rear partition there was a bench like area facing inwards and the bars extended down to the level of the bench like seats in relation to the area covered by the seats. The central portion consisted partly of a solid white partition which extended from the floor for a distance above the level of the seats and by bars similar to those on either side to the roof. The height of the white solid partition between the ends of the seats was approximately twice the height of the seats and approximately half the height of the van. The rear area of the van is sufficiently low that it is impossible to stand up in it without stooping. At the rear of this prisoner area there is a door with bars reaching to the floor which was shut once a prisoner was in and immediately behind that door were the back doors of the van which again were shut during transit. Photographs J2 – R2 show the police cell van.

35 Constables Laybourne and MacDonald were concerned as to how to place Mr Mitchell in the van. They had regard to their training on ensuring the safety of a prisoner. They considered that handcuffed to the rear and in his volatile drunken state (he was continuing to shout, swear and move around) that if he was placed on either of the benches at the side of the van that he could fall off and injure himself. They decided to, and did, place him on the floor of the van with his back to the partition wedged by his bulk between the two bench like seats with his head and shoulders above the level of the top of the partition. He would be visible from the front part of the van. Because of the constricted space Mr Mitchell's legs were bent at the knees with his feet against the back door. The light in the rear part of the van was on and remained so through the subsequent journey.

36 The practice of placing a prisoner on the floor of a cell van was not a common one but it had been seen before by Constable Laybourne. Sergeant Brown and Constable Duffy, as well as Retired Inspector Ian Rule. All agreed that prior to December 2008 this was an accepted method of moving prisoners in a cell van when there was concern that because of their state they could injure themselves by falling off the seat.

37 In March 2009 at the result of this tragedy a directive was issued to all Police Officers in Strathclyde Police from the Assistant Chief Constable. Its terms were:-

> "A procedural review has recently taken place as the result of an incident within the cell compartment of a marked police cell van. The following recommendations have been made as a result of that review.

> When transporting a prisoner within the cell area of a police cell van, officers should not place the prisoner in the foot well of the cell area, as this position gave a restricted view of the prisoner. Officers must ensure, especially if the prisoner is vulnerable due to intoxication, injury or some other factor, that there should be an unrestricted view and verbal communication with the prisoner at all times during the journey."

38 Constable Duffy drove the van from Cumbernauld to Monklands Hospital, Airdrie, a journey which took approximately fifteen minutes. Constable Bowman was in the front passenger seat and spoke to Mr Mitchell twice during the journey. He received no response but was not surprised as many prisoners refuse to speak to police officers while they are being transported. Constable Bowman also raised himself from his seat and looked back towards the rear. He could see Mr Mitchell's head and the top of his shoulders. These two occasions occurred when the van was on the A73 (which is the main road between Cumbernauld and Airdrie) and again after the van had entered Airdrie and was between the Rawyards roundabout (which is the first roundabout on entering Airdrie from Cumbernauld) and the Top Cross (a junction about halfway between the Rawyards roundabout and the hospital). By that point in the journey the van was between three and five minutes away from the hospital.

39 The journey was completed when the van arrived at the Admission point of Monklands District General Hospital and while Constable Duffy secured the front of the van, Constable Bowman went inside the entrance to fetch a wheelchair to take Mr Mitchell in.

40 Constables Laybourne and MacDonald had followed in a police car intending to take over responsibility for Mr Mitchell. Constable Laybourne reached the rear of the cell van and on opening the rear door observed that Mr

Mitchell had slipped down although his back was still against the wall area. His feet came out of the van door area and his condition, colour and lack of response caused her to call for immediate help.

41 Constables MacDonald and Laybourne applied CPR and were joined almost immediately by doctors and nurses. Mr Mitchell was taken within the hospital and for twenty-five minutes every possible effort was made to revive him. This involved four doctors and three nurses. At 8.45 pm he was pronounced dead by Dr Neil Howie.

42 An immediate investigation into the circumstances was undertaken by two senior independent police officers. The cell van, the ambulance, and the taxi were all examined and photographed that night. All the police officers concerned supplied statements and records were recovered. Photographs of the various loci were taken. CCTV footage from Cumbernauld and Monklands District General Hospital were recovered and put into a format which was shown in court.

43 A post mortem was carried out by Dr John Clark and Dr Linda Iles at Monklands Hospital on 30 December 2008. It left the cause of death as "unascertained." Despite the carrying out of numerous tests, a thorough review of all the reports and records by Professor Anthony Busuttil, there is no evidence to establish on a balance of probabilities the cause of Mr Mitchell's death.

EVIDENCE

44 No witness deliberately misled the court and all did their best to tell how he or she recollected the events of 23 December 2008. Some were more accurate than others and this is probably due to the passage of time, the shock of being

involved in such a tragedy and in the natural differences in recollection which can occur.

45 Finding 1 can be made from the information contained in the affidavit by Miss Sarah Carrick as well as Mr Mitchell's GP records (Production No 11) and the Registrar's Information (Production No 5).

46 Findings 2 – 4 arise from the affidavit of Anne Hendry, and the evidence of Kenneth Fitzpatrick and Anna Hudson who worked at the Red Triangle Snooker Club and Michael Moore who worked at Morriarty's and George Clark who was a customer that day. While there were various estimates as to exactly what Mr Mitchell had to drink it was clear that in both establishments he had a considerable amount. His blood/alcohol reading (contained on page 2 of the Toxicology Report attached to the Post Mortem Report, Production No 4) confirms this.

47 Finding 5 is based on the terms of the Affidavit by Alistair McLean, a security guard who operated the CCTV covering the area outside Moriarty's and outside the Friary, the video showing the relevant passages of that CCTV footage and the evidence of Miss Karen Burns.

48 Finding 6 is based on the evidence of George Clark and that of the taxi Driver, Zulfiqar Raja Haider.

49 Findings 7, 8 and 9 are based on the evidence of Mr Haider, of another taxi driver who was in Burns Road at the time, Graham Stronach and on the evidence of Michelle Herron and Aileen Grey who were in the flats nearby. It was suggested that the sound of Mr Mitchell's head striking the road could be heard within an eleventh floor flat. I reject this as had the impact been as great as that

Mr Mitchell would have suffered a devastating head wound at least. Instead his cut was described by the ambulance personnel as "a nick" and "minimal." I also reject the evidence as mistaken which suggested that Mr Mitchell fell towards Mr Haider's taxi and not away from it. The clear weight of the evidence supports the view that he fell backwards away from the taxi and ended with his feet closest to the taxi.

50 Finding 10 is based on the recording of the 999 call in which Mr Mitchell can be heard clearly shouting abusively. The ambulance centre records (Production No 9) and the evidence of Mr Haider and Miss Herron confirm the 999 calls.

51 Findings 11, 12 and 13 arise from the evidence of the two ambulance technicians. I am certain that they had more than reasonable cause to be concerned by Mr Mitchell's behaviour and that they welcomed the arrival of police officers who had authority to move Mr Mitchell and to protect them from Mr Mitchell's threats and violent gestures.

52 Findings 14 – 19 and 23 came from the evidence of the police officers. I preferred their evidence to that of the ambulance personnel as to the extent of Mr Mitchell's aggression. This may be the result of the police officers being more used to the behaviour of very drunk persons. I was impressed by their moderate descriptions of events in Burns Road. With little difficult they could have found sufficient evidence to charge Mr Mitchell with a Contravention of Section 41(1)(a) of the Police (Scotland) Act as well as a Breach of the Peace. The evidence of the ambulance personnel was however clear and in line with the police evidence that Mr Mitchell was examined, assessed and treated, that his injury was minimal and that had he agreed to accept the advice to go to hospital he would have been taken. They also were both of the opinion, stated to

Constable MacDonald in particular that Mr Mitchell did not require hospital treatment and that they had no power or authority to compel a patient against his well to go to hospital.

53 Findings 20 – 22 are supported by the evidence of Constables Laybourne, Stevenson and Walton. Again Mr Mitchell's behaviour resisting attempts to get him to enter the police car and his behaviour during the journey could, in the minds of other less tolerant officers, have resulted in further charges.

54 Findings 24 – 31 are based on the evidence of Sergeant Brown supported by the other officers present and Mr Michael Docherty, the custody and security officer.

55 Finding 32 is based on Sergeant Brown's evidence, on the terms of Production No 7 and on the evidence of Inspector Annette Morrison who compiled Production 7. It arises also from the evidence of Sergeant Dawn Dunnion who reviewed the circumstances in relation to this part of the events.

56 Finding 33 arises from the evidence of Constables Duffy, Bowman, Laybourne and MacDonald.

57 Finding 34 is based on the description of the inside of the cell van given by various officers and from the Photograph J2 – R2. One police officer suggested as an estimate that the size of the area into which Mr Mitchell was placed was similar to the witness box but this was, I believe, an imprecise view and I was unclear whether he was referring to the witness box itself or merely the width of it. The photographs and the other police evidence contradicts this assessment of the length of the footwall area and I preferred that evidence.

58 Finding 35 is based on the detailed evidence of Constable Laybourne and Constable MacDonald. They considered the options and reached their decision after careful consideration. Constables Duffy and Bowman were not involved in the decision making.

59 Finding 36 arises from the evidence of these officers. While other officers spoke to not having seen prisoners conveyed in this way, it was clear from Sergeant Brown, who had fourteen years police experience, and Constable Duffy, who had eight years, that this was a method used in December 2008 to move intoxicated prisoners for their own safety.

60 Finding 37 relates to the terms of the directive (Production 8). Inspector Morrison who was responsible for its compilation spoke to it and confirmed that it had been circulated to all Strathclyde Police and its terms would be incorporated into the next review of the chapter "Prisoners; Custody Care and Welfare" in the Strathclyde Police Operating Procedures (Production 7)

61 Findings 38 and 39 arise from the video of the call van's arrival at Monklands Hospital and the evidence of Constables Duffy and Bowman. The former was driving the cell van and naturally had to concentrate on this task. She did not try to see Mr Mitchell during the journey. She confirmed that he had changed position from where he had been placed at Cumbernauld when she first saw him at Monklands. As however by that time Constable Laybourne had opened the van doors and Mr Mitchell's legs had moved because of this, I do not think she is able to assist as to how far Mr Mitchell had slipped during the journey. She was however clear that her colleague Constable Bowman had spoken to Mr Mitchell twice during the journey and that on the A73 and again between Rawyards Roundabout and the Top Cross in Airdrie, he had turned to see Mr Mitchell. Constable Bowman's evidence was in line with this and he was

clear that he could see Mr Mitchell's head and shoulders. I accept that evidence as correct. The position of the Rawyards Roundabout, the Top Cross and Monklands Hospital are based on judicial knowledge which, had I wished, I could have had confirmed by the Airdrie based officers.

62 Constable Laybourne spoke of her intense shock on seeing Mr Mitchell when they arrived at the hospital. The video shows the arrival of the cell van followed very shortly by Constable Laybourne reaching the rear doors and opening them. Finding 40 is based on this evidence.

63 Finding 41 is made as the result of the evidence of Constables MacDonald, Laybourne, Duffy and Bowman, the video taken from both outside and inside the hospital entrances, the detailed evidence of Dr Howie and the hospital records (Production 10).

64 Finding 42 is made on the basis of the evidence given by Detective Inspector Ian Rule, the officers who were interviewed that night and the affidavit evidence of Jim Pringle, James Gallagher and Alistair John McLean (in relation to the CCTV evidence), Linsey McNulty in relation to the 999 recordings and Roslyn Douglas who took photographs on 23 December.

65 Finding 43 arises from the evidence of Dr John Clark and Professor Busuttil, the terms of the post mortem report (Production 4) including the various toxicology and other reports based on tests carried out and Professor Busuttil's own report dated 20 January 2010.

CAUSE OF DEATH

66 A fundamental issue for the Inquiry was to find if it could be established what was the cause of death. The Rules of Evidence for a Fatal Accident Inquiry shall be "as nearly as possible those applicable in an ordinary civil cause brought before a Sheriff sitting alone" (Section 4(7) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976). It therefore follows that there is no need for a Sheriff to be satisfied beyond a reasonable doubt or any such standard of proof. Provided a matter, including the cause of death is established on a balance of probabilities that is sufficient.

67 The evidence of Dr Clark and the terms of all the detailed reports covering *inter alia* toxicology, neuropathology and histology still left the cause of death as unascertained. Dr Clark agreed with my summary of his evidence that "The cause of death was not trauma, it was not a stroke, it was not drug induced and there was no evidence to show the normal signs of a heart attack. I discount liver problems as a cause of death because of the presence of a high level of alcohol and the lack of drowsiness in the period before death. The blood alcohol level could have caused death but there is no evidence to confirm this and he was a heavy drinker. There is no evidence to support positional asphyxia and without pure speculation, in my opinion, the cause of death remains unascertained".

68 Dr Clark, who is a very experienced forensic pathologist, clarified what, to a lay person, may have seemed a strange conclusion that liver problems could be ruled out because of the presence of a high alcohol reading. He explained that in cases where liver problems cause death, the demise occurs at a time when there is no alcohol present and is preceded by a period of drowsiness. He also

explained that a blood/alcohol reading of 345 mg/100 ml could cause death in some but that in the case of a heavy drinker, such as Mr Mitchell, this was less likely and that there was no evidence to support such a finding.

69 Professor Busuttil reviewed all the documents and records as well as considering a full summary of the events and times of Mr Mitchell's known movements during 23 December. He was clear that there was no evidence to support a finding that positional asphyxia had caused this death. Dr Clark supported this assessment. He felt that alcohol was unlikely to be the cause and suggested that cardiac arrhythmia was the most likely possibility but that there was no post mortem finding or evidence to support this. He would not have expected any sign to be present at post mortem and he agreed that in the absence of any sign or fact at post mortem that, in his view, was a matter of speculation.

70 In the light of the evidence given by Dr Clark and Professor Busuttil I have concluded that it is impossible to state a cause of death and accordingly I will require to find that it was unascertained.

SUBMISSIONS

71 I received written submissions from all three parties to the Inquiry. Each helpfully divided their submissions in relation to each of the sub-sections of Section 6(1) of the Act.

72 The Fiscal and the representative of the Chief Constable of Strathclyde Police invited me to find that Mr Mitchell had died at Monklands District General Hospital on 23 December 2008 when life was pronounced extinct at 20.45 hours by Dr Neil Howie. Mr Thomson, on behalf of the relatives, suggested that death had occurred in the rear of the police van while Mr Mitchell was in

transit as a prisoner from Cumbernauld Police Office to Monklands Hospital Airdrie between the hours of approximately 8.10 pm and 8.25 pm. He asked me to find that Mr Mitchell had been dead on arrival at the hospital.

73 Mr Thomson based his contention on the evidence of Constable Laybourne that when she opened the door of the police van that Mr Mitchell's face was purple and that he had stopped breathing. I do not accept that this established that Mr Mitchell was dead at the time he arrived at the hospital. Constable Laybourne described him as "unconscious" and it was clear from the evidence given by Dr Howie that attempts to revive him were made by medical and other staff until he was finally pronounced dead at 8.45 pm. I also find support from the report by Professor Busuttil and, in particular, paragraph six, when he points out that when somebody has collapsed that there could be a chance of survival provided steps are taken within a short period. I therefore cannot say on a balance of probabilities that Mr Mitchell died in the course of the journey to Monklands Hospital and I require to find that the time of his death was the time certified by Dr Howie.

74 Both the Fiscal and the representative of the Chief Constable asked me to find that the cause of death was "unascertained" in accordance with the findings of Dr Clark and Dr Iles. They contended that Professor Busuttil's evidence supported this view. Mr Thomson argued that I could find that the cause of death was cardiac arrhythmia contributed to by a number of factors including the presence of a large quantity of alcohol, a history of hypotension, cardiac scarring, acute agitation and confusion, a degree of mild and non-fatal positional asphyxia and the presence of Tranadol in the blood. He did this on the basis of paragraph five of Professor Busuttil's report.

75 As I have indicated, it is necessary for me to make a finding based on the balance of probabilities. Having considered all the evidence and, in particular, the detailed findings made at post mortem and the evidence of Dr Clark who conducted the post mortem and therefore was able to see if there were any signs which would give a clue to a probable cause of death, there is an insufficient weight of evidence to make a finding based on a balance of probabilities. Accordingly I must find that the cause of death is unascertained.

76 In terms of Section 6(1)(c) the Fiscal invited me to find that nothing had occurred up to the point where a decision was made to move Mr Mitchell to Monklands Hospital which would give any ground for suggesting that there was a reasonable precaution whereby the death might have been avoided. She contended, and I agree, that the actions of the police officers at Burns Road and those of the ambulance personnel who attended there cannot, under any circumstances, be criticised. Mr Mitchell was a very drunk, abusive and aggressive man and was totally unco-operative. Constables Laybourne and MacDonald did what they could to get him to the ambulance and to supervise him there while he was examined by qualified ambulance personnel. In the light of Mr Mitchell's repeated and persistent refusal to accept the advice that he should go to hospital (even if it was not in the opinion of the ambulance personnel necessary) it was appropriate for the police officers to arrest him, as they did. The decision to transport him in a car to the police station and his treatment in the police station did nothing to contribute to his death and cannot in any circumstances be criticised.

77 Likewise, Sergeant Brown's decision that medical opinion should be obtained before he was detained in a cell was entirely appropriate. The duty sergeant has a responsibility for the safety and wellbeing of prisoners in his care and while it may have been purely precautionary to obtain such an opinion,

Sergeant Brown was perfectly entitled, and it was equally appropriate, that such an opinion should be obtained before Mr Mitchell was put into a police cell when he could not be observed constantly.

78 The Fiscal invited me to consider whether a finding under Section 6(1)(c) could be made to the effect that had Mr Mitchell been observed constantly by a police officer during the journey from Cumbernauld to Monklands Hospital the change in his condition might have been spotted more quickly and appropriate steps taken to deal with that thereby preventing the death.

Mr Thomson supported this argument emphasising that sub-section (c) uses the word "might." He contended therefore that I did not need to find matters proved to the same standard as is required in relation the other sub-sections. In particular, Mr Thomson emphasised that even if the cause of death remained as "unascertained" it would be possible to speculate that no matter what the cause of death it "might" have been avoided had immediate steps been taken to get Mr Mitchell help as soon as his condition changed in the back of the van.

79 I accept that there is some basis for the argument that Mr Mitchell was not as closely supervised during the journey as he might have been. In retrospect Constable Bowman accepted this. Constable Duffy was driving the vehicle and could not be expected to undertake this task but Constable Bowman could have been expected to ensure that he was aware of Mr Mitchell's wellbeing. In relation to this he spoke to him on two occasions but received no response, (something which did not surprise him as he was aware that prisoners often did not speak to police officers in the course of a journey) and he observed him by raising himself from the seat of the van and looking backwards on two occasions.

80 Mr Mitchell had been placed in the van by Constables Laybourne and MacDonald. They had left him in a position whereby his head and shoulders were above the solid division part which separated the back from the front of the van. He was therefore in a position where he could be observed by Constable Bowman. If, as I do, I accept the evidence of Constable Bowman that on the two

occasions on which he turned to look at Mr Mitchell that he could observe his head and shoulders I require to conclude that on the last occasion when he did that observation Mr Mitchell's condition had not changed to the extent that he had slumped down to the position he was found in by Constable Laybourne when the vehicle arrived at Monklands Hospital.

Mr Thomson argued that such a finding could not be made because Constable Bowman had not checked the position of Mr Mitchell before the journey started and accordingly it was possible that he had slumped down while the vehicle was travelling between Cumbernauld Police Office and the A73. I do not accept this argument as it is not consistent with the evidence given by Constable Laybourne as to the position in which she had left Mr Mitchell when she had placed him in the van and the position she found him in when she opened the doors at the hospital. When she placed him in the van at Cumbernauld his head was up. When she saw him in opening the door at Monklands his chin was against his chest and he had slipped down the partition. Had he been in that position before Constable Bowman observed him while the van was on the A73 then Constable Bowman would not have seen Mr Mitchell's head and shoulders in a normal position as he indicated he did. It is even unclear whether if Mr Mitchell had slumped down before the first observation that Constable Bowman could have seen his shoulders at all as they may well have been below the level of the top of the solid partition.

81 There was no directive or other instructions to police officers in relation to the placing of prisoners in the back of cell vans nor was there specific instruction that they required to be observed and spoken to constantly. Following Mr Mitchell's death such an instruction has now been issued and I am satisfied that its terms are clear and should be followed in future by all police officers.

82 It therefore follows that in the absence of such a document in December 2008 and based on the evidence of Sergeant Brown, DI Rule and Constable Laybourne that it was accepted that people could be placed in the back of a cell

van on the floor because of their drunken condition and the potential danger to themselves, that the decision to put Mr Mitchell in that position cannot be criticised. It would not be a reasonable precaution in December 2008 to have put him in a different position nor is there any evidence to suggest that that would have saved his life.

There therefore remains the question as to whether had Constable Bowman kept Mr Mitchell under constant observation or had he checked him between the last time he did so within the Burgh of Airdrie and the arrival at Monklands Hospital whether that might have prevented the death.

83 I have reached the conclusion that it would not. Had Constable Bowman observed that Mr Mitchell had slumped down it would have been possible to stop the police vehicle immediately to ascertain the cause of it. On reaching the inside of the vehicle Constables Duffy and Bowman would have realised that Mr Mitchell's condition had worsened. As they did not have a defibulator or anything other than basic first aid equipment they could either have sent for urgent medical help or alternatively resumed their journey at high speed to the hospital.

84 Had they waited for medical help from the hospital then the resulting delay would have resulted in more time passing than in fact did occur in this case by them travelling normally to the hospital. Had they resumed their journey and travelled at high speed to the hospital the time spent in ascertaining Mr Mitchell's condition and then resuming the short journey from the top half of Airdrie to the hospital would probably have been longer than the original journey and most certainly would not have been shorter.

85 I have accordingly reached the conclusion that once I have accepted that the change in Mr Mitchell's condition occurred between the time he was last observed by Constable Bowman between the Rawyards Roundabout and the Top Cross that there was no reasonable precaution whereby the death might have been avoided. While it could be argued that a reasonable precaution

would have been to observe Mr Mitchell more rigorously there was no instruction for a police officer to do so. Furthermore I am satisfied that even with such intense observation the time space between the change in Mr Mitchell's condition and his arrival at hospital is sufficiently short, that it cannot be stated even on the wide scope allowed by sub-section (c) that the death might have been avoided.

86 Mr Thomson was critical of the decision to use the small cell van but I am satisfied by the evidence that this was a normal vehicle used on many occasions by Strathclyde Police and that as it was the vehicle available it was appropriate that it be used.

87 Mr Thomson was also critical of the decision not to arrange for Mr Mitchell's transfer by ambulance. There would, he contended, have therefore been available all the appropriate emergency equipment to dealt with Mr Mitchell's collapse. In my view, there was no justification whatsoever for calling an ambulance and it would have been totally inappropriate. Ambulances are intended to deal with genuine emergencies, not to act as a taxi service to the hospital when there are limited ambulance resources available. There were two ambulances based in Cumbernauld and they required to be available to deal with any emergency that might arise and also to provide cover for other areas if the need arose. There was absolutely no justification for diverting an ambulance from its normal duties for more than half an hour in order to transfer Mr Mitchell from Cumbernauld Police Office to the hospital particularly when the decision to take him to hospital was merely to obtain a precautionary medical opinion.

Mr Thomson was critical of Constables Laybourne and MacDonald in their decision to put Mr Mitchell in the position they did. He put it to Constable Laybourne that she had "shown a disregard for her prisoner's safety." This suggestion, which clearly upset Constable Laybourne, was, in my view, totally unjustified. Constable Laybourne, in particular, and Constable MacDonald

displayed, in my view, every possible care and attention for the welfare of their prisoner. They carefully considered the various options and had regard to his drunken condition and their fear for his safety if he was placed on the bench. They accordingly chose to put him in what they regarded as the safest possible position, wedged between the two benches because of his size and in as comfy a position as possible with his legs in a "W" position. I considered that the two officers are to be commended for their standard of care towards Mr Mitchell and that no criticism whatsoever can be directed at them and I therefore reject Mr Thomson's suggestion.

88 I am also satisfied that the existence of the new directive in relation to the transporting of prisoners in cell vans is an appropriate reaction to this tragic death but should not under any circumstance be taken as an indication that the system which existed in relation to the placing of a prisoner in such a position was inappropriate at December 2008. I consider that passage which requires officers to ensure that they have visual and other contact with the prisoner is appropriate. Had it been in force in December 2008 it would however not have altered the tragic outcome because of the timescales involved between the time that Mr Mitchell's condition did not give cause for concern, his apparent collapse and his arrival at the hospital.

In relation to Section 6(1)(d) the Fiscal suggested that I make no finding. It could not be suggested that there was evidence that there had been defects in any system of working which had contributed to the death. She emphasised the difference between sub-sections (c) and (d). Sub-section (c) allows a Court to consider what "might" have caused the death to be avoided whereas sub-section (d) acquires an affirmative finding that a defect in the system of work existed and that that defect contributed to the death.

The representative of the Chief Constable supported this view contending firstly that there had not been any defects in any system of working and that furthermore even if I found that there had been any defects they had not contributed to the death.

In support of this new point, both Mrs McGarrity and Miss Ali submitted that the police officers had correctly arrested Mr Mitchell as he was drunk and incapable, that they were correct in their use of handcuffs to restrain him, that Sergeant Brown was entitled to seek medical confirmation that Mr Mitchell could be detained in a cell, and therefore it was appropriate that he should send Mr Mitchell to Monklands District General Hospital and that Constables MacDonald and Laybourne had placed Mr Mitchell in what was considered to be the safest possible position because of his intoxicated state and in order to prevent him falling. The officers had acted in accordance with the Police Standard Operating Procedures and in accordance with what was accepted practice by a number of experienced officers. In any event, there was no evidence to suggest that had matters been dealt with in any different way they could be shown on a balance of probabilities that the death could have been avoided.

Mr Thomson argued that I should make a finding in terms of sub-section (d). He suggested that Mr Mitchell's medical history, which was available on the police computer records, should have been communicated to the officers who were dealing with him directly. I do not accept this argument for two reasons. Firstly, I am not clear that there was anything in the records which would have altered the way in which Mr Mitchell was dealt with even if it had been known (the information was general and limited). Secondly, I am not satisfied that even Sergeant Brown had the necessary information available to him before Mr Mitchell left Cumbernauld Police Office.

Mr Thomson also argued that Sergeant Brown should have made enquiry about the availability of an ambulance or other police vehicle to transport Mr Mitchell. For the reasons which I have already given, I do not consider there were any grounds whatsoever for seeking an ambulance and the van used was a standard one used constantly by Strathclyde Police.

Mr Thomson also contended that because Sergeant Brown was unaware that the cell van at Cumbernauld could not be used due to a defect there had been a delay in transporting Mr Mitchell because an alternative van had to be obtained from Coatbridge. It would have been totally inappropriate to take Mr Mitchell in the back of a police car because of his aggressive behaviour and the potential danger to police officers in the course of the journey. During the time that it took for the van to come from Coatbridge Mr Mitchell was under constant supervision and observation by Constables Laybourne and MacDonald and there is, in my view, no grounds for suggesting that that delay was not entirely appropriate nor that it, in any way, was a factor which is relevant to Mr Mitchell's death.

A further point raised by Mr Thomson was that the issue of supervision of Mr Mitchell was not discussed between Constables Laybourne and MacDonald on the one hand and Constables Duffy and Bowman on the other. I do not consider that there is any substance in this point. Constables Laybourne and MacDonald appreciated that they had a responsibility to place Mr Mitchell in the best possible position taking into consideration all the relevant factors. This they did. Constables Duffy and Bowman knew that they had a responsibility to transport Mr Mitchell to the hospital and Constable Bowman knew that he had a responsibility to observe Mr Mitchell and he did so. I do not see any purpose would have been served by discussion between the four officers before the journey started.

Mr Thomson's final point under this sub-section was that officers should receive specific training on the positioning of an accused within police vehicles. Again, I do not consider that this is relevant to this death. Firstly, it was very clear that Constables Laybourne and MacDonald had given very careful and thorough consideration of what position Mr Mitchell should be placed in the back of the van. They were following the procedure which Constable Laybourne had seen before, which Constable Duffy had also seen before and which other even more experienced officers accepted took place before December 2008. The issuing of the new procedure from March 2009 has now clarified the need to ensure that a prisoner is kept under observation and is communicated with and, in particular, that a person should not be placed on the floor of a cell van. I do not believe that there is any evidence that the placing of Mr Mitchell on the floor of the cell van has been shown on a balance of probabilities to cause or contributed to his death, the cause of which is "unascertained." Equally, for the reasons which I have given I am satisfied that there is no evidence to the appropriate standard to show that Constable Bowman's limited observation (in the sense that he only turned twice to check Mr Mitchell in the course of the journey) was a relevant factor to his death. Accepting, as I do, the evidence of Constable Laybourne in relation to the position in which she and Constable MacDonald placed Mr Mitchell at the start of the journey and her evidence as to his changed position when she opened the van doors at Monklands Hospital, I have to conclude that the change in Mr Mitchell's position and condition occurred during the short period while the van was travelling within the Burgh of Airdrie.

Under Section 6(1)(e) the Fiscal invited me to find that Mr Mitchell was a chronic alcoholic who had started drinking when he was a teenager. She also invited me to note that the medical records and the evidence given by Mr Mitchell's sister indicated that he had in the past been treated for respiratory problems.

While I accept that these two facts are correct I do not consider it appropriate that I should make a formal finding in relation to either. In relation to the first point, it was Mr Mitchell's behaviour on the night which led to his falling, injuring his head and subsequently being arrested as drunk and incapable. The fact that he clearly was a chronic alcoholic whose drinking habits had started as a teenager are, in my view, not relevant to his death as it was his condition and behaviour on the particular night which were the factors which led to the circumstances of that evening. I also think it would be unfair for Mr Mitchell's relatives to include such a finding in the formal Determination which may then be passed to the Registrar with a view to clarifying particulars on a Death Certificate.

Although Mrs Carrick indicated that her brother had had respiratory problems and the GP records and Dr Walker-Love's affidavit confirms this, there was no evidence that his respiratory problem had caused his death nor was there any evidence that any of the people involved on the night were aware of his past problems to the extent that would have influenced their actions.

This was a very distressing Inquiry and it is easy to understand how Mr Mitchell's relatives were concerned to find that the cause of his death appeared to be "unascertained." They may still be perplexed as to how two very experienced and highly qualified pathologists (Drs Clark and Iles) could not make any positive findings despite all the tests which were subsequently undertaken. They may also be surprised that a world recognised authority (Professor Anthony Busuttil) could not be sufficiently definite in his evidence to clarify the situation. I hope that they appreciate that Mr Mitchell's death comes into the tiny number of cases each year in which, despite the best possible medical opinion and the benefits of all the research and tests available, it

remains impossible to state what the cause of death was. A number of possible causes have been eliminated and I have dealt with those earlier.

I have carefully considered the points made by Mr Thomson and by Mr Mitchell's relatives as to how far it is possible to make findings when the cause of death remains "unascertained." If it could have been shown that whatever the cause of death Mr Mitchell's life might have been saved had a reasonable but different course of action been taken then I would have been prepared to make a necessary finding. I have however concluded that this is not the case and accordingly after an Inquiry which lasted for six days I have concluded that I have to limit my Determination.

I am very grateful to the legal representatives for their careful and thorough presentation of their arguments. This has been a very anxious Inquiry for Mr Mitchell's relatives but it has also been an anxious Inquiry for certain Police Officers and it is important they, and particularly Constables Laybourne and MacDonald, appreciate that, in my view, the evidence established that they had acted in a sympathetic, competent and professional manner throughout their dealings with Mr Mitchell.

For the relatives of Mr Mitchell I can only repeat what I stated in the Court at the end of the hearing that they have the Court's deepest sympathy in their sad loss. Mr Mitchell was a popular person and his very sudden death, around Christmas time, must have been a particular blow to all who knew and loved him.

A major burden of presenting the evidence in this case fell upon Mrs McGarrity. The care and thoroughness with which she had investigated and researched the evidence and the manner in which she presented it to the Court

cannot be faulted in any way. I believe that everybody involved in the Inquiry will be grateful to her for the hard work which she had put in; I certainly am as it assisted me considerably in considering numerous facets which arose in the course of the evidence. Both Mr Thomson and Miss Ali presented the respective interests in respect of which they had been instructed in a thoroughly professional and competent manner. I understand in relation to all three that this was their first Fatal Accident Inquiry and if that is indeed so then the standard of presentation and argument was quite exceptional.

I accordingly Find and Determine as follows:-

The Sheriff, in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Section 6(1) Finds that Leslie John Mitchell (Date of Birth 01 May 1957) who resided at 6A Morrison House, Burns Road, Cumbernauld died at Monklands District General Hospital at 8.45 pm on 23 December 2008 and that the cause of death is "unascertained."