DETERMINATION BY WILLIAM HOLIGAN INTO THE DEATH OF NEIL DEMPSTER REILLY

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 WILLIAM HOLLIGAN, Esquire, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on 22 - 26 September and 18 and 19 December 2003 into the death of NEIL DEMPSTER REILLY, date of birth 3 September 1962, who resided at 65 Main Street, Bridgeton, Glasgow, who died on 13 October 2002.

GLASGOW, 15th January 2004.

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

(1)That NEIL DEMPSTER REILLY, date of birth 3 September 1962, residing at 65 Main Street, Bridgeton, Glasgow died on 13 October 2002 within Glasgow Royal Infirmary.

(2)That the death was caused by hypoxic brain damage due to inhalation of stomach contents due to acute alcohol intoxication.

(3)That

(a) the removal to hospital, when initially detained, at approximately 2.40 am on Sunday, 13 October 2002 at Main Street, Bridgeton; and

(b)the removal to hospital from London Road Police Office to Glasgow Royal Infirmary on the morning of Sunday, 13 October 2002;

were reasonable precautions whereby the death might have been avoided.

NOTE:-

In this matter I heard evidence on 22-26 September and 18 and 19 December 2003.

Mr Bell, the procurator fiscal depute, appeared for the Crown; Mr Skinner, advocate, for the family of the deceased; Mr Mowat for Sergeant McDowall; Mr Vaughan for PC Paton; Mr O'Hagan for PC Twaddle; Mr Leslie for John McGowan and Mr Campbell for the chief constable.

The Inquiry concerned the death of Neil Dempster Reilly whom I will refer to as "Mr Reilly". I set out the following chronology.

Chronology

[1] On Saturday evening 12 October 2002 Mr Reilly was in the Londoner Bar, London Road in Bridgeton. Amanda Johnson, a barmaid, knew Mr Reilly. He arrived in the pub some time after 7.00 pm and left a little before midnight. She could not say for certain how much alcohol Mr Reilly had consumed but said he was not drunk when he left the pub. He seemed in a good mood when he left. Mr Reilly's home address was Main Street, Bridgeton, some 4 minutes walk from the pub. Miss Johnson said that Mr Reilly did not come into the pub every evening after work but would come in at the weekend and on days off.

[2] Jean Boreland was coming home to her flat at 51 Main Street, Bridgeton at approximately 2.00 am on Sunday, 13 October 2002. She saw a man sitting in the close next to hers. He was sitting on the ground with his knees up. He was moving. She did not approach or speak to him and assumed he was drunk.

[3] Esther McNulty and Thomas Hannah were returning from a night out on Saturday, 12 October 2002. They both live in Main Street, Bridgeton. They came home by taxi. When they were walking to their close Mr Hannah noticed a man asleep in an adjoining close. It was some time after 2.00 am. He approached the man, spoke to him but got no response. He was alive and breathing. He was not dishevelled but looked well dressed. He was wearing a jacket. He was wearing a watch and his keys were on the ground. It was a cold night. Both Mr Hannah and Miss McNulty said "He had a drink in him". He was uninjured but Mr Hannah described him as unconscious. There was a police car in the vicinity. Mr Hannah and Miss McNulty were concerned for the man's safety and that his property might be stolen. The man was Mr Reilly. They flagged down the police vehicle.

[4] PC Kenneth McDonald and PC Neil McFadyen were on uniform mobile patrol at approximately 2.40 am. They were approached by Miss McNulty and Mr Hannah about a man in a close. PC McDonald was the senior of the two officers and took the lead in deciding

what to do. They approached Mr Reilly. He was asleep. He was checked for injuries. No injuries were found. He was not dishevelled. PC McDonald and PC McFadyen tried to rouse him. PC McDonald pressed a key into Mr Reilly, something he had seen an ambulance driver do. Mr Reilly mumbled but said nothing coherent and went back to sleep. PC McDonald decided to take Mr Reilly to the police station at London Road. He decided Mr Reilly be taken in a police van. When the van arrived PC McDonald and PC McFadyen helped Mr Reilly to the van. Mr Reilly's feet were scuffing the ground and his feet were dragging. He was placed in the van and conveyed to London Road Police Office, a drive of approximately 3 minutes. PC Lorraine Lorimer was in the van with Mr Reilly. He did not speak or make any sound in the course of the journey. PCs McDonald and McFadyen followed behind in their patrol car.

[5] On arrival at London Road Police Office, with the assistance of another officer, PCs McDonald and McFadyen carried Mr Reilly into the police office and placed him on the floor adjacent to the charge bar area. This occurred at approximately 2.50 am. The custody sergeant on duty at the time, Sergeant McDowall, was not present when Mr Reilly was admitted to police custody. Mr Reilly was admitted by PC Paton. PC Paton was on duty as a male turnkey. The other male turnkey was Force Support Officer (FSO) McGowan. PC Paton has not received any training as a custody officer other than training in how to operate the prisoner processing system, a computer system concerning the admission of prisoners. He was asked to be male turnkey the night before. He had carried out this duty before. At the time Mr Reilly arrived at London Road Police Office Sergeant McDowall was on his tea break having been on duty for 71/2 hours without any substantial refreshment. PC Paton tannoyed Sergeant McDowall who rang PC Paton from the canteen. PC Paton told Sergeant McDowall that Mr Reilly was drunk and incapable. He asked Sergeant McDowall if he (Sergeant McDowall) wanted PC Paton to process Mr Reilly. Sergeant McDowall said yes. PC Paton proceeded to process Mr Reilly.

[6] During the time he was at the charge bar area Mr Reilly remained on the floor. He was placed in the recovery position by PC McFadyen. He did not speak. He made a number of incoherent noises. He waved his arms. He sneezed several times. He was searched by PC McFadyen. PC McFadyen drew attention to some matter on Mr Reilly's lip which PC McDonald thought was not blood but Buckfast wine. PC McDonald checked for signs of injury but found none. Crown labels Nos 1-3 are the videos of events at the charge bar area and beyond. Crown production No 19 is a transcript of words said at the charge bar area.

[7] Crown productions Nos 4 and 5 are a copy of the custody record completed by PC Paton on Mr Reilly's arrival at London Road Police Office. Mr Reilly was not informed of his right to have a reasonably named person or a solicitor informed of his detention. PC Paton entered "No" in both the boxes dealing with these issues believing that the computer programme required that the questions be answered. It does not. Mr Reilly was entered as being "completely incoherent, no injuries". PC Paton entered Mr Reilly as being drunk.

[8] Mr Reilly was conveyed to Cell No 20 by PC McDonald, PC McFadyen and another officer. He was placed in the recovery position, covered by a blanket, with his face to the

wall. He was snoring. The cell hatch was left open. PC McDonald asked PC Twaddle to "keep an eye" on Mr Reilly.

[9] PC Paton asked PC Twaddle to look in at Mr Reilly. PC Paton spoke to Sergeant McDowall on the latter's return from his tea break some time after 3.00 am. PC Paton did not tell Sergeant McDowall that for part of the time at least Mr Reilly had been processed whilst lying on the ground on his back nor that Mr Reilly could not speak. PC Paton did visit Mr Reilly in his cell at about 3.05 am. He did not make an entry to that effect in the prisoner processing system.

[10] Sergeant McDowall was trained to be a custody sergeant. Visits to a prisoner in a cell should be recorded in the computer system. On the night of 12/13 October 2002 one of the force support officers was on holiday. PC Paton was a stand-in. There was a system for recording visits by means of a bar code but it had been out of commission for some time prior to this incident. Crown production No 11 is an instruction from Chief Superintendent Smith, the Divisional Commander of E Division, which includes London Road Police Office, reminding custody sergeants that they must be present during the processing of a prisoner. It is dated 4 October 2002. It was seen by Sergeant McDowall prior to 13 October 2002. Sergeant McDowall visited Mr Reilly at approximately 3.20 am. He shook Mr Reilly by the right shoulder. He asked Mr Reilly if he was all right. Mr Reilly's snore changed to a grunt. Sergeant McDowall asked PC Twaddle to keep an eye on Mr Reilly. Sergeant McDowall did not give any specific instructions to either PC Paton or FSO McGowan as to the frequency or content of their visits to prisoners. He relied upon both officers knowing when to carry out their duties and what to do.

[11] Crown production No 6 is a copy of a record of visits made to Cell 20 during the early hours of 13 October 2002. There are two entries timed at 3.00 am and 3.40 am respectively which bear to narrate that Mr Reilly was visited in his cell by FSO McGowan. The entries are wrong. Mr Reilly was not visited on either occasion, or at all, by FSO McGowan. FSO McGowan made these entries.

[12] On the morning of 13 October 2002 PC Twaddle was assigned to watch a prisoner in Cell 40. This is an observation cell for prisoners thought to be at risk of suicide. PC Twaddle was not trained as a bar officer or as a turnkey. He had carried out these duties on previous occasions and had picked up information from colleagues. PC Twaddle understood that he was to "look in" on Mr Reilly and "look in" did not mean communicate or touch. PC Twaddle accompanied Sergeant McDowall on the latter's visit to Mr Reilly's cell at approximately 3.20 am (3.29 am on the CCTV system). Between 3.36 am (as per CCTV) and 4.14 am PC Twaddle looked through the hatch of Cell 20 at Mr Reilly at intervals of approximately 10 minutes. On each occasion (excluding the last) PC Twaddle saw Mr Reilly snoring, facing the wall and breathing. As recorded by CCTV at 4.14 am PC Twaddle and Sergeant McDowall entered Mr Reilly's cell. Mr Reilly had stopped breathing. Attempts were made to resuscitate Mr Reilly with the assistance of a number of officers. An ambulance was summoned. Mr Reilly had inhaled the contents of his stomach. The ambulance arrived at approximately 4.20 am. Notwithstanding the efforts of the paramedics, they were unable to start Mr Reilly's heart. Mr Reilly was conveyed to hospital at approximately 4.45 am.

[13] Mr Reilly arrived at Glasgow Royal Infirmary at approximately 4.50 am. He was seen by medical staff immediately upon his arrival at hospital. After 20 to 30 minutes some cardiac output was recorded but there was no breathing. By the time Mr Reilly had arrived at the hospital his position was irretrievable and it was inevitable that he would die. Death was pronounced at 1445 hours on 13 October 2002.

[14] The cause of death was hypoxic brain damage due to inhalation of stomach contents due to acute alcohol intoxication.

Commentary

[15] The Inquiry heard from the following witnesses: Amanda Johnson, Jean Boreland, Esther McNulty, Thomas Hannah, James Sheehan, Dr Jocelyn Britliffe, Dr Noel Hemmings, Dr Gregor Imrie, Dr Alistair Ireland, PC Lorraine Lorimer, PC Kenneth McDonald, PC Neil McFadyen, PC Kirsteen McIntyre, Sergeant James Shields, Thomas Finlay, PC David Paton, John McGowan, PC Stuart Twaddle, Sergeant Robert McDowall, Inspector Gavin Bone, Sergeant James Stewart, Inspector William Caie, Chief Superintendent Kevin Smith, Dr John Clark, Mr Harry Miller, Catriona Renfrew, Superintendent Alistair McKie and Dr Jason Payne James. In the main, and unless said otherwise, I found the witnesses to be reliable and credible.

[16] From the chronology I have set out it is clear that Mr Reilly was admitted into police custody in a drunken state. He went to the Londoner Pub some time after 7.00 pm and remained there until about closing time (midnight). Although there were slight differences as to timing, it was clear that Mr Reilly was found sitting in a close doorway some time after 2.00 am. What the Inquiry does not know is what happened to Mr Reilly in the period between midnight and 2.00 am. There is no evidence that he left the pub carrying alcohol. Some of the local witnesses (Jean Boreland and Esther McNulty) were asked about restaurants in the vicinity but I think it would be speculation to say that Mr Reilly obtained more alcohol locally. We know from the toxicological report (production No 3) that Mr Reilly's blood alcohol level was 308 milligrams of alcohol per 100 millilitres of blood. There was evidence from Dr Clark and Dr Payne James that the blood alcohol level rises after consumption of the last drink before it begins to fall. The medical evidence is that this level of blood alcohol was high. Harry Miller, who manages the Albyn House Centre in Aberdeen, a centre which specialises in looking after drunk people, said that a level of 400 milligrams would lead to transport to hospital from the Albyn Centre. Dr Clark estimated that the reading of 308 milligrams would equate to approximately 15 pints of lager. This issue was yet further complicated by the fact that alcohol affects different people in different ways; some have greater tolerance than others. My conclusion, and I do not think it was ever suggested otherwise, is that at the time Mr Reilly was first seen by the police he was in a severely intoxicated state. I reach that conclusion not just on the basis of the foregoing but also upon the evidence put before the Inquiry as to the physical condition Mr Reilly was in.

[17] Jean Boreland saw Mr Reilly but took no action. Esther McNulty and Thomas Hannah drew the attention of PCs McDonald and McFadyen to Mr Reilly. They were concerned as to his welfare and for the safety of his property. His keys were on the ground. Mr Reilly was not dishevelled. He was well dressed. He had not soiled himself. I add that Mr Reilly was not known to the police and according to Chief Superintendent Smith the police had no records of him. Mr Reilly was known to Amanda Johnson, the barmaid at the pub, as someone who came into the pub at weekends but not every night. It was also her evidence that he left the pub in a cheerful frame of mind. What led to his intoxication that night is not something the Inquiry knows.

[18] Of the two police officers approached by Esther McNulty and Thomas Hannah, PC McDonald was the most senior. His attention was drawn to Mr Reilly at approximately 2.40 am. PC McDonald approached Mr Reilly. He found no signs of injury. Mr Reilly was asleep. He was incoherent. He did not speak. At best he mumbled. He smelled strongly of alcohol. PC McDonald pressed a key into Mr Reilly in an effort to rouse him, something he had seen an ambulance driver do. In PC McDonald's opinion Mr Reilly presented as a classic case of drunk and incapable. He had seen many such cases in his experience as a patrol officer. He made the judgement to have Mr Reilly conveyed to London Road Police Office. He did so for Mr Reilly's safety and welfare. He did not believe Mr Reilly ought to be left in the cold on his own. He said he did consider the option of sending him to hospital but declined to do so. That decision was based upon his experience. A van was summoned to transport Mr Reilly to London Road Police Office. Given his intoxicated state I would not expect the police to have conveyed him in a patrol car.

[19] At the point of being taken into custody PC McDonald had two choices open to him: either convey Mr Reilly to the police office or send him to hospital. As I have him noted, PC McDonald had no specific criteria to when to choose between the two options. He said he would consider sending to hospital if there were signs of injury, particularly head injuries. He said he had experienced cases where ambulance staff had said that the individual was "one for you boys". There was put before the Inquiry a number of documents (to which I shall refer in detail later) setting out practices and procedures to follow for the care and welfare of prisoners. There appears to be no equivalent dealing with the point of detention itself. Dr Payne James, an experienced casualty surgeon, providing services to, amongst others, the Metropolitan Police Service in London, was of the opinion that Mr Reilly should never have been conveyed to a police station at all but should have been taken to hospital in the first place on account of his level of intoxication. The risks to very drunk persons were not in dispute. Either, depending upon the level of intoxication, (a) the drunk person may suffer heart or brain damage or failure or (b) as in this case, the person's gag reflex will not work properly with a result that the person may inhale his own vomit. That will prevent oxygen reaching the brain which can lead to brain damage or, after 3 to 5 minutes, death. Such tests as do exist to assess the intoxication of a drunk person are, if I have understood the medical evidence correctly, geared towards assessing the level of consciousness of the drunk person. As Dr Payne James said, at the point of detention the person's blood alcohol may yet rise. The police are not in a position to make a medical judgement about a drunk person's condition but, as Dr Payne James commented, their training should be directed towards awareness of the issues and the risks involved. Whereas there is material before the Inquiry to show there are procedures available at the point of detaining in a police office, there appears to be no equivalent for patrol officers. My determination includes a finding to

the effect that it would have been a reasonable precaution to have conveyed Mr Reilly to hospital rather than have him taken to a police office. Mr Reilly was in an intoxicated state and severely so. There was no distinct verbal response and he was unable to walk unaided. In so finding I do not criticise the actions of PC McDonald. He had to make a judgement in the light of the training and experience he had. Objectively, it would have been a reasonable precaution to take Mr Reilly to hospital.

[20] Mr Reilly was conveyed to London Road Police Office. Mr Reilly was assisted into the charge bar area and laid on the floor. He was searched and the rights of the accused forms completed. The Inquiry had played to it a video tape, with sound, of the events that took place at the charge bar area. There was also a transcript (Crown production No 19) of what was said, prepared by a member of Strathclyde Police. In his submission Mr Campbell, solicitor for the chief constable, made no attempt to justify what occurred at the charge bar. He was right to adopt that stance. To their credit neither Sergeant McDowall (who was not present) nor PC Paton (who was) sought to defend what occurred there. Mr Reilly was the object of ridicule. His treatment was quite unprofessional. Whereas I do not condone it, I am not overly critical about the language used by the police. Whereas one might lament the coarsening of language in our society, in the real world swearing does go on and the police force is not exception. However, what I do not understand is the stance adopted by PC McDonald and PC Colin Stark who both denied swearing. It was plain for all to see and hear that they did. There was a video, transcribed as I have said, by a colleague. There were no civilian witnesses present - Mr Reilly could not speak.

[21] It is clear that the practices and procedures then in place for the admission of prisoners were not followed. PC Paton completed the rights of accused form (Crown production No 4) which narrates that Mr Reilly did not wish a solicitor or other person notified of his detention. Mr Reilly could not speak and was never asked. The form bears to have been completed by Robert McDowall. It was not. Sergeant McDowall never appears to have seen the form. PC Paton seemed to think that the "fields" giving the answers to the questions concerning contact with solicitors and other persons had to be completed otherwise the form itself could not be completed, ie the computer would not allow him to proceed on. There was evidence from Mr Finlay that this belief was quite wrong. It is also clear that PC Paton had never been trained in the duties of custody sergeant and was not acting in such a role in any official capacity. On Mr Reilly's arrival at London Road Police Office, Sergeant McDowall, the custody sergeant on duty, was on his tea break. He was contacted by PC Paton who, with Sergeant McDowall's approval, proceeded to process Mr Reilly and admit him to custody. That process did not comply with the correct procedure. The correct procedure was for the custody sergeant himself to be present at the point of admission. This was emphasised in a memo from Chief Superintendent Smith dated 4 October 2002 addressed, inter alia, to custody sergeants. Sergeant McDowall accepted that he had received a copy of the memo. The decision to admit a prisoner into custody is a responsible one calling for the application of knowledge gained from training and experience. That PC Paton may have seen many drunk and incapable persons before is neither here nor there. An independent decision has to be made at the point of admission. Crown production No 20 is a copy of the training scenario put before custody sergeants, showing a set of facts similar to that presented by Mr Reilly. The trainer, Sergeant Stewart, said that the correct decision was that the prisoner be sent to hospital and not be admitted to police custody. Whatever PC Paton and Sergeant McDowall may have discussed on the telephone as to Mr Reilly's condition that was no

substitute for Sergeant McDowall making his own assessment. Having said that, it appears that Sergeant McDowall had been on duty for 71/2 hours without any substantial refreshment. It was suggested that he could have sought support from other sergeants or inspectors. Chief Superintendent Smith said that Sergeant McDowall ought to have risen from his break and resumed it after processing Mr Reilly. I am not much impressed with the suggestion that Sergeant McDowall could have sought support elsewhere. In practical terms there was no-one easily available and it did not seem to occur to Sergeant McDowall that this was an option open to him at the time. There was no system in place for that to happen and the idea that he might call on another sergeant, in another office, or ask a senior officer for help is not convincing. Although it may be stating the obvious, custody sergeants need to know that prisoner processing takes priority over breaks or, alternatively, a formal system whereby a qualified officer takes over during breaks needs to be put in place. Should Mr Reilly have been admitted at that point? The training example I have referred to suggests not. Inspector Caie of "A" Division was confident he would never have admitted him. Inspector Bone, Chief Superintendent Smith and Sergeant Stewart, all, according to my notes, would not consider a grunt a "distinct verbal response". (See Crown production No 9). Dr Payne James clearly did not consider Mr Reilly a suitable candidate for admission. Having said that, I think a number of witnesses accepted that an element of judgement is called for. However it does seem to me that it would have been a reasonable precaution to have sent Mr Reilly to hospital at that point. As I have said the question is one of precaution. There was in my view, ample material to justify taking such a step at that stage.

[22] Mr Reilly was admitted to London Road Police Office at approximately 2.45 am. PC Paton said (and I accept his evidence) that he looked in on Mr Reilly some time shortly after 3.00 am. There is a facility to record all cell visits and a record exists for Mr Reilly. PC Paton did not record his visit. The record of visits (Crown production No 6) narrates that Mr Reilly was visited by FSO McGowan at 3.00 and 3.20 am (his reference number is 500656). The evidence is that the turnkeys on duty are not instructed upon the regularity and content of their visits as a matter of course. It is left to them to arrange between or amongst themselves. FSO McGowan was trained in his duties. PC Paton was not. He said that he had "picked up" his responsibilities from observing others. I am surprised the turnkey officers appear to have no formal training, especially when one considers the controversy as to what a visit to a drunk person should comprise. In particular, Crown Production No 9 refers to the frequency and content of visits to prisoners. It refers to the need to check for "a distinct verbal response". If none is obtained immediate consideration needs to be given to removal to hospital. This is a responsible decision. It requires awareness of the risks to drunk persons. Unfortunately it is also clear from the evidence that FSO McGowan did not, in fact, carry out the checks which he recorded against his name. He said he entered the first visit because he felt sure someone would have done so. He was unable to give an explanation for the second entry. On any view the entries are wrong, they did not happen.

[23] Sergeant McDowall returned from his tea break. The record notes a visit at approximately 3.20 am (I should add that the CCTV clock was out of sequence with the computer clock - see paragraph 5 of the Joint Minute). Sergeant McDowall said that Mr Reilly was snoring which changed to a grunt when shaken by the right shoulder. Mr Reilly's arm "flailed" in the air. PC Twaddle accompanied Sergeant McDowall on the visits. In Sergeant McDowall's opinion Mr Reilly could be left. His face still lay to the wall. Putting and leaving Mr Reilly facing the wall was clearly not appropriate. His face and mouth not be

seen. (See Crown production No 10 which refers to the findings of another Inquiry relating to a death in custody). He asked PC Twaddle to keep an eye on him. He appears not to have given any specific instruction along the lines of production 9, ie that visits be undertaken every 15 minutes or what PC Twaddle ought to do on such a visit so as to check Mr Reilly's rousability. PC Twaddle was on suicide watch at Cell 40, a short distance from Cell 20, Mr Reilly's cell. As I have set out, PC Twaddle was asked by more than one officer to assist with Mr Reilly. It was described as an "obligement". Whatever instructions were given to PC Twaddle they were, at best, in very general terms and did not contain any specific instruction as to what he was to do, how he was to do it or how often. PC Twaddle seems not to have had training as a turnkey nor to have occasion to consult guidelines recently as to the care and welfare of prisoners. He did look through the hatch cover at intervals of approximately 10 minutes. It was his evidence that he saw some movement from Mr Reilly and that he was breathing. It was not until Sergeant McDowall, again with PC Twaddle, entered the cell some time after 4.00 am, that it was discovered Mr Reilly had stopped breathing and had inhaled his own vomit. An ambulance was summoned without delay. From that point onward it seems to me that all which could have been done for Mr Reilly was done but the tragic result was almost inevitable. In my opinion PC Twaddle did what he was asked to do. He had no specific instructions or training as to what to do.

[24] So far as my determination is concerned, all parties are agreed that, in relation to Section 6(1)(a) and 6(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") there is no dispute. I have made the necessary determination.

[25] I make a number of observations.

[26] One of the issues debated before me was whether it would have been a reasonable precaution to convey Mr Reilly to hospital. I hope I do no disservice to the argument by summarising it as follows. Given that an intoxicated person can die within 3 to 5 minutes (and the precise estimates within that time varied) and given that such a person might have been left on a trolley unattended in a hospital, the outcome might well have been the same as a police office. While that might be an argument in the context of causation (and I express no view on that) I am dealing with "reasonable precautions...whereby the death...might have been avoided". The evidence from Glasgow Royal Infirmary is to the effect that all patients are assessed by an experienced triage nurse. One of the assessment tools is the Glasgow Coma Scale. That initial assessment would determine what management is appropriate thereafter. I cannot accept that there is no qualitative difference between being in hospital and being in a police cell. Just because the outcome might not have been different does not mean that it would not be a reasonable precaution to send to hospital. I was also urged to find that it would have been a reasonable precaution for Mr Reilly not to have consumed so much alochol. Whereas that might logically be correct I do not find it a convincing argument. It seems to me that the correct starting point is when Mr Reilly was found at the close in Main Street, Bridgeton.

[27] There was a lot of evidence concerning the meaning and application of various guidelines. Crown productions No 9 and its identical equivalent No 24 were in force at the relevant time. Crown productions Nos 21 (and its laminate version No 22) are more specific

than Nos 9 and 24. They post-date the incident although their genesis began at some point earlier in the year. Dr Payne James referred to the "four Rs" which find application in Nos 21/22 (Rousability, Response to questions, Response to command, Remember possibility of injury). There was considerable debate amongst the witnesses as to the meaning of "distinct verbal response" as set out in Nos 9 and 24. Nos 21 and 22 are more specific. They require more of those checking drunk prisoners. Nos 9/24 call for 30 minute visits, shorter periods if required, perhaps every 15 minutes. There was evidence that custody sergeants had been trained or reminded of their duties as per Nos 21/22. However, it seems to me that may only be part of the picture. In large quantities, alcohol is a poison and a poison which can kill. Its widespread availability and consumption masks that fact. We should not, in my opinion, overlook the fact that police officers are asked to make judgements as to the levels of toxins in a person whom they find. Were it any other poison other procedures might be followed. In my view Dr Payne James put the matter well when he described his function as educating the police as to the awareness of the risks to health associated with alcohol. Police should not be left with the responsibility of making what may be medical judgements. It seems to me that procedures would be improved if information given to officers included an explanation of the fundamental issue which underlies the precautions, namely (a) concentration on assessing levels of consciousness (ie why rousability is so important) (b) the risks to a drunk person (i) heart or a brain failure or damage and (ii) inhalation of vomit leading to brain damage or death. Further, it seems to me that such information and training should go to all of those who have dealings with very drunk people. That includes not only custody sergeants but also patrol officers and turnkeys. The evidence before me was to the effect that patrol officers and turnkeys did not have any training on these issues or any recent training. I appreciate it may be thought that such training is unnecessary on the basis that all officers know what to do with drunk people. However, when one looks at the differing responses from the officers, some of them very senior, to the facts here there appears to be no unanimity of view or practice.

[28] That leads me to a further part of the evidence upon which I have not yet touched. Parliament has recognised for some time that alternative arrangements should be made for drunk persons. Section 16 of the Criminal Procedure (Scotland) Act 1995 (formerly Section 5 of the Criminal Justice (Scotland) Act 1980) authorises the establishment of "designated places" for accommodating drunk people. The Inquiry heard evidence from Mr Harry Miller who manages Albyn House, Aberdeen. Over the period from August 1983 to October 2003 Albyn House has received almost 15,000 referrals from Grampian Police. Most of the referrals come from Aberdeen city. On receipt of the referral a risk assessment is carried out which includes the use of a breathalyser machine which can be operated by mouth, or if the referral cannot do so, nasally. A reading in excess of 400 milligrams leads to a referral to hospital. Initially referrals are checked every 5 minutes for the first half hour and then every 15 minutes stretching to every 30 minutes. By all accounts this scheme has worked well. There are plans to extend the scheme to Edinburgh. There is one other designated place in Inverness. Albyn House is funded by NHS Grampian and Aberdeen City Council Social Work Department. The Inquiry heard from Catriona Renfrew of Greater Glasgow Alcohol Team which is a multi-agency team concerned with all those who have an alcohol problem, covering both prevention and treatment. The issue of designated places in Glasgow arose for debate in the 1980s and again in 2000. The first discussion arose before Miss Renfrew's appointment. The second arose at the instigation of the NHS authorities who were concerned that A & E Departments were having to deal with drunk people when there was no clinical need. Although it was recognised that there was a potential for a designated places scheme in Glasgow the enormous gaps in provision for dealing with alcohol related

problems, and the absence of any funding, meant that the matter went no further. There are currently no proposals for such a scheme in Glasgow but there is a proposal for an "arrest referral scheme" so as to give resources to police to decide whether a referral can be made to other services rather than arresting a person. Superintendent Alistair McKie gave evidence. He spoke about the work of the Glasgow Homeless Partnership which exists to deal with, amongst other things, alcohol related matters. This group has discussed the establishment of designated places and has considered them favourably. This group were unanimous that drunk and incapable persons should not be dealt with within the criminal justice system. Over a 5 year period up to April 2003 the number of drunk and incapable persons received into police custody fluctuated between 1,000 and 1,600 per annum. Although the establishment of designated places remains on the agenda of his group and all seem in favour of it there is no funding for such a scheme. I should add that Superintendent McKie's evidence was to the effect that drunk and incapable persons are really a health issue but the police deal with them. Both Inspector Caie and Chief Superintendent Smith were of the view that the police should not be responsible for the arrest of drunk and incapable persons. It respectfully appears to me that the tragic of death of Mr Reilly and the evidence led highlights not just the issue of how such persons are and should be dealt with under current arrangements but whether such arrangements should not be the subject of a more extensive review. As I have already noted Parliament has acknowledged the problem by enacting Section 16 of the Criminal Procedure (Scotland) Act 1995 but has not provided resources to secure its implementation. There are fundamental issues as to whether such persons should be treated as raising health issues or a criminal justice issues. Some of these issues have been touched upon in the evidence before me. There are clearly major policy and resource issues which fall to be resolved. There was evidence put before the Inquiry as to the determination issued in another Inquiry following the death in custody of a drunk person. My concern is that there is a continuing risk of this occurring. Whereas this Inquiry can make certain recommendations it respectfully seems to me that the issue is broader and would benefit from a wider review. I shall direct the Sheriff Clerk, pursuant Section 6(4) of the 1976 Act, that a copy of my determination and Note be sent to the Minister of Justice to deal with as is thought appropriate.

[29] I summarise the following matters which I suggest require further consideration:-

(a) that consideration be given to adjusting the current guidelines and training as to the care of drunk and incapable prisoners so as to emphasise the risks to prisoners and that training emphasises the importance of the level of consciousness of the person.

(b) that consideration be given to extending such training both to patrol officers and turnkey officers.

(c) that consideration be given to the use of breathalyser machines to assist in determining the level of intoxication of very drunk prisoners.

(d) that custody sergeants be specifically instructed that a prisoner cannot be admitted to custody outwith their presence and without their approval or that there be established a system whereby custody sergeants can summon assistance if they are unable to attend.

(e) that consideration be given to reviewing an extension to the availability of "designated places" under Section 16 of the Criminal Procedure (Scotland) Act 1995 and/or the care and welfare of persons found in an intoxicated state.

SHWH.JH.06.01