SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

Inquiry held under the Fatal Accidents
And Sudden Deaths Inquiry (Scotland)
Act 1976

DETERMINATION

By

Sheriff Kathrine EC Mackie

Following an Inquiry held at Edinburgh on 29th, 30th, 31st May and 1st June 2007 into the death of STUART GRAHAM FOSTER

Edinburgh, 20 July 2007

The Sheriff having considered the evidence adduced and submissions thereon, DETERMINES in terms of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976

1. That, in terms of section 6(1)(a), Stuart Graham Foster, born on 13th July 1976, who resided at 161 Ferry Road, Edinburgh, died between the hours of 5am and 7.30am on 11th June 2004 within motor vehicle registration number N510 JRT parked outside 3 Trafalgar Street Edinburgh.
2. That in terms of section 6(1)(b) the cause of death was (a) aspiration of gastric contents and (b) acute alcohol intoxication.
3. That in terms of section 6(1)(c) Stuart Graham Foster's death might have been avoided had one or other of his colleagues, employees of Luminar Leisure Limited 3 West Tollcross Edinburgh who were within the Cavendish Nightclub during the early hours of 11th June 2004 called for medical assistance at any time between 3.50am and 5am.

4. That in terms of section 6(1)(e) the acceptance by Stuart Graham Foster and his colleagues of a culture of "binge" drinking to a state of extreme intoxication and collapse contributed to his death.

NOTE

[1] The inquiry held into the circumstances of the death of Stuart Graham Foster (hereinafter referred to as Stuart Foster) who resided latterly at 161 Ferry Road Edinburgh and who died on 11th June 2004 proceeded in terms of section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. It did not fall within the category of inquiries which must be held following a death but was an inquiry which the Lord Advocate had considered expedient in the public interest having occurred in circumstances such as to give rise to serious public concern.

[2] Evidence, including the viewing of a DVD compiled from CCTV footage of the deceased taken within the nightclub premises then known as the Cavendish, was led by the Procurator Fiscal over four days from 30th May to 1st June 2007. On 31st May, at the invitation of all parties, I visited the premises which although having undergone some refurbishment remain largely as they were on 11th June 2004. At the conclusion of the evidence I heard submissions from the Procurator Fiscal, Mr Foster senior and MrMcKenzie on behalf of Luminar Leisure Limited (hereinafter referred to as Luminar).

[3] I would observe that the time which has elapsed since Stuart Foster's death had a detrimental effect upon the recollections of most of the witnesses who did not have the advantage of being able to refresh their memories by reference to reports prepared at the time. I formed the view that the majority of those witnesses were credible but not entirely reliable. Some of Stuart Foster's former colleagues, perhaps understandably, appeared to be defensive in their account of events leading to his death while others appeared self serving.

[4] Stuart Graham Foster was born on 13th July 1976. He was described as a happy sociable person, a valued employee who was enormously popular with

his colleagues. He was employed by Luminar Leisure Limited as a bar tender at their place of business at The Cavendish 3 West Tollcross Edinburgh. The Cavendish, now known as Lava Ignite, is a nightclub operating under an entertainment licence issued by the City of Edinburgh Council with a regular extension of permitted hours allowing the sale of alcohol until 3am each day. In June 2004 Mr Foster was living temporarily in a flat occupied by one of his colleagues, Rachel Simnett, at 161 Ferry Road Edinburgh.

[5] On 10th June 2004 Mr Foster started work at about 9.30pm. He was due to work until 3am. The venue was less busy than had been anticipated. Miss Simnett, who was the bar supervisor, told him that he could finish at 1am. This was agreed with David Pennycook, the senior bar supervisor or trainee manager who was in charge of the venue. Instead of leaving Mr Foster remained at the Cavendish.

[6] A CCTV system is operated inside and outside the Cavendish. A DVD compiled from that system (Crown label number 1) shows Mr Foster sitting down or wandering about the nightclub between about 3am and 3.50am. He appears to be holding a bottle. Despite the very high alcohol reading subsequently obtained, 451mg of alcohol per 100ml of blood, the evidence of what he was drinking between 1am and 3.50am was, at best, vague. In the venue there are a number of bars in different areas. It was suggested that as a result it was difficult to keep a check on what people were drinking if they moved round the various bars. Mr Foster appears to have had a staff drink, probably an alcopop, when he finished working. He may have had more alcopops or shots, applesours or sambucca, in the company of Jacqueline Caldwell, another colleague who finished work early. He was seen with one or possibly two bottles of Charmain, a low alcohol sparkling wine available usually as a gift to parties or as a prize from the Disc Jockey. It is impossible to say whether his colleagues were genuinely unaware of the amount he was drinking. There was no evidence to suggest that he was not sober at 1am. Accordingly it is clear from the alcohol reading that he consumed a very large amount of alcohol between finishing work at 1am and 3.50am when he appears to fall asleep in a chair.

[7] Between 3.50am and about 4.35am when he was assisted from the premises Mr Foster was unresponsive to any stimulus employed. His hat was removed, a jacket was placed over his head and left there for about two minutes, a glass of water was poured over his head. He was held in place in the chair by a hand on his shoulder. At about 4.22am he fell onto the floor. An attempt to rouse him by lifting him was unsuccessful and he was left lying on the floor. He remained on the floor, without moving. A jug of water was poured over him without any response. Eventually he was lifted up by Rachel Simnett and another colleague, Richard Wishart at about 4.30am. They assisted him outside and placed him in the rear of Rachel Simnett's car, registration number N510 JRT. Richard Wishart, one of the bar staff, said that he and Rachel Simnett decided to "carry" Mr Foster to the car because he could not stand unaided. He said he was mumbling incoherently but did try to walk. He also said that he was a bit sick, as though he had drunk a lot of juice and foam was coming up, just inside the staff entrance to the premises. Mr Foster was placed on his right side on the rear seat.

[8] Miss Simnett arrived at her flat shortly before 5am. She parked her car in Trafalgar Street, Edinburgh. She was unable to rouse Mr Foster and was unable on her own to remove him from the car to take him into the flat. She decided to leave him in the car. She brought a pillow from the flat and placed that under his head. She said he grunted as she did so. Prompted by reference to a statement given to the police she recalled that she had noticed some dark liquid dribbling from his mouth which she wiped away. She tried unsuccessfully to contact her flatmate, Susan Smith, a nurse. She intended to ask her to check on Mr Foster when she returned from her shift at about 8am.

[9] At about 11am Miss Simnett went to the car to check on Mr Foster and found him dead. She asked her flatmate to attend to him. Susan Smith telephoned 999. The call was received by the Scottish Ambulance Service at 11.25 and an ambulance attended at 11.29. I heard evidence from Gary Baldie, a paramedic with eleven years experience. He observed a male lying on his right side in the rear seat of the motor car. There were no vital signs. He noted substantial post mortem staining with rigor mortis present. He also noted some bleeding from the nose. The absence of any pulse or respiratory function was noted at

11.30am. There was nothing he could do. Police attended shortly thereafter and arranged for the police surgeon to attend. Dr Rachel Millar pronounced life extinct at about 13.40.

[10] I also heard evidence from Professor David Harrison, who carried out the post mortem examination, and Professor Gerhard Kernbach-Wighton who had considered the post mortem findings. Estimating the time of death was described by Professor Harrison as witchcraft and incredibly inaccurate. From the presence of rigor mortis observed by the paramedic the medical evidence was that death had occurred at least four hours before Mr Foster was found. On the basis that Mr Foster was alive when Miss Simnett placed the pillow under his head at about 5am it is appropriate that I find that death occurred between 5am and 7.30am on 11th June 2004 within the motor car registration number N510 JRT parked in Trafalgar Street Edinburgh.

[11] Professor Harrison's report (production number 12) records aspiration of gastric contents following upon acute alcohol intoxication as the cause of death. The only physical abnormality noted was bloodstained frothy secretions in the trachea, mouth, bronchi and lungs. A strong smell of alcohol was also noted. There was no evidence or physical indication of drug taking. Blood and urine samples sent for laboratory analysis disclosed alcohol in the blood of 451mg per 100ml and in the urine of 500mg per 100ml (production number 13). This level of alcohol in the blood is equivalent to 5.6 times the upper limit for driving and is within the fatal poisoning level. Bruising noted on the upper right arm may be consistent with attempts to lift him from the floor but was considered by Professor Harrison to be a couple of days old. I am satisfied that death was caused by aspiration of gastric contents following upon acute alcohol intoxication.

[12] Medical evidence indicated that alcohol has depressive effects. When present in very high levels, above 300mg per 100ml of blood, it affects respiration and circulation. In particular it depresses the cough reflex which protects the body against aspiration of foreign material into the airways. The likelihood of vomiting is increased but the body's ability to protect the airways is reduced leading to the aspiration of gastric or stomach contents. The only treatment is support of bodily functions with monitoring of respiration,

circulation and kidney function. Intubation is also carried out to alleviate aspiration of stomach contents and to avoid respiratory arrest. Professor Kernbach-Wighton said that if medical intervention was received before aspiration the likelihood of survival was virtually 100% but if after aspiration the likelihood of survival was significantly reduced to less than 50% because of complications which may arise such as pneumonia.

[13] Mr Baldie had experience of attending intoxicated persons. An attempt would be made to take a patient's history and how much alcohol had been consumed. Painful stimuli would be used to attempt to rouse an individual. The earlobe or sternum would be pressed hard. If there was no response then the patient could be considered unconscious as opposed to asleep. He was unable to say if pouring cold water over someone would provoke a response if they were only sleeping. If the person was unable to care for themselves, unable to walk or talk then they should be conveyed to hospital for proper assessment and monitoring.

[14] The medical evidence indicates that if any of his colleagues with whom he was between 3.50am and 5am had called for medical assistance the death of Mr Foster might have been avoided. The chance of survival would have been almost 100% had there been medical intervention before any aspiration had occurred. Mr Wishart said that Mr Foster had been a little sick near the staff entrance to the premises as he was being assisted to Miss Simnett's car. Miss Simnett did not see him being sick at any time but did tell the police that she had seen some dark liquid dribbling from his mouth before she left him at 5am. If Mr Wishart's evidence were accepted aspiration is likely to have occurred at about 4.35am. I have reservations about the reliability of Mr Wishart's evidence in relation to Mr Foster's condition as he was being assisted from the premises and placed in Miss Simnett's car. I formed the impression that he was anxious to depict Mr Foster as being more alert and more capable than he may have been.

[15] There was no evidence about the time which it would have taken for an ambulance to arrive if called in the early hours of the morning. The ambulance which did attend at 11.29am arrived within four minutes of the call being received. I was referred to the Determination by Sheriff Stephen into

the circumstances of the death of John McGrady dated 31st January 2001. The circumstances of Mr McGrady's death, which was also caused by aspiration of gastric contents following acute alcohol intoxication, appear to bear a number of similarities with the circumstances of Mr Foster's death. In that case Sheriff Stephen heard evidence that, at least in 1999, in the early hours of the morning the likely period from a call to the Scottish Ambulance Service and arrival at the locus would have been within six minutes. Mr McKenzie on behalf of Luminar accepted that if a call had been made to the Scottish Ambulance Service Mr Foster would have been likely to have received appropriate medical assistance within ten minutes. On that basis, if a call for medical assistance had been made at about the time that Mr Foster fell onto the floor, at 4.22am, it is likely that an ambulance would have arrived before aspiration had occurred. It is possible that aspiration would still have occurred before Mr Foster could have been admitted to hospital leading to complications which may have reduced his prospects of survival. Professor Harrison did say that in general patients do survive.

[16] For the purposes of section 6(1)(c) of the 1976 Act it is not necessary for there to be evidence that the death "would" have been avoided by the taking of any reasonable precaution but only that the death "might" have been avoided by such a step. Accordingly I am satisfied by the medical evidence that Mr Foster's death might have been avoided had one of his colleagues called for medical intervention at any time between 3.50am and 5am.

[17] There is no doubt that Mr Foster's colleagues failed on 11th June 2004 to take the action which might have prevented his death. A central issue at the Inquiry was whether that failure could be attributed to an inadequacy of training by Luminar.

[18] Luminar employed a Health & Safety Manager, Mr Anthony Steed. His responsibility was to devise a health & safety policy and system for the company which would satisfy their statutory and common law obligations. As at June 2004 the policy in operation was that a first aider should be present in a venue when persons, including staff, were there. The Health & Safety Executive require such a first aider to have completed a four day training course. Someone who had completed only one day's course might be

considered a first response, able to make an injured person comfortable and to call for medical assistance. Each venue had access to the Health & Safety manual which was regularly updated. It was the responsibility of managers of the venues to act upon the material and guidance provided. From time to time audits would be carried out.

[19] All employees of Luminar were required to undergo an induction programme and to complete an Award of Merit booklet. If the employee indicated an intention to progress further in the company a programme of career development existed whereby an employee would complete in turn a bronze, silver and gold level booklet. Upon completion of each booklet an appraisal meeting would be held with the employee's superior, usually a member of management, and then the booklet would be sent to Luminar's training department who would evaluate the entries in the booklet. After completing the gold level an employee could enter the trainee management programme supervised by the University of Loughborough. Such an employee would work through a course of study with regular meetings with someone at Area Manager level. From the copy booklets produced (Luminar's productions nos 4, 6, 7 and 40) it is clear that first aid is mentioned only in the Award of Merit and bronze level booklets. In the former the employee is asked only to identify the first aiders in his venue and where first aid kits are kept. In the latter the employee is recommended to undertake a first aid course, to know the recovery position and to place an injured person, if appropriate, in the recovery position and get proper help. Accordingly mere completion of the booklets would not appear to provide any guidance or training of what to do in a medical emergency.

[20] All employees were required to undertake a Servewise course under the auspices of Alcohol Focus Scotland. A more advanced course known as Servewise plus was available to those who were progressing to management. Servewise courses are designed for those working in the licensed trade to heighten their awareness of relevant legislation, the nature and effects of alcohol and drugs and how to deal with customers. At the end of the Servewise course each participant would be issued with a booklet (Crown production no 22). At pages 16 to 17 of the booklet available in 2004 there is

information about the nature of alcohol and its effect upon the brain. At pages 34 to 35 five steps are set out to cope with a medical emergency. These are

- Call for help immediately
- Call an ambulance (or ask someone to do it for you)
- Check if the person is breathing or not
- Check that their airways are clear
- Loosen any tight clothing especially at the neck and waist.

[21] David Pennycook maintained that he had little or no recollection of the content of the booklets completed by him or of any course undertaken by him. He recalled that to obtain the gold level he had completed a project on "upselling" that is boosting sales. He also remembered undertaking a one day first aid course when he pretended to put a bandage on someone. He maintained that he learned "on the job". The evidence was that he had also undertaken the Servewise plus course and the Scottish Licensee Certificate. Rachel Simnett, who appeared to be a credible and reliable witness, also had difficulty in recollecting any training. She had attained the silver level. She maintained that it was not unusual for employees to copy others' answers in the booklets to be completed and that the emphasis of management was on the completion of the booklets so that it appeared as if staff had been trained. Thomas Lang, General Manager of the Cavendish in June 2004, confirmed that he was aware of the practice of copying entries in the booklets. He maintained it did not happen often but he took no steps in relation to the practice apparently leaving it to Head Office to pick up if they could. Rachel Simnett had undertaken part of the Servewise course and had been involved in a one day Servewise course which had been delivered for the purpose of assessment by Alcohol Focus of the people delivering the course, including Thomas Lang. Jacqueline Caldwell said that she had completed the booklets herself and was not aware of anyone copying entries. She had attained silver level. She said she remembered being trained that if someone needed medical attention a first aider, usually a member of management or a door steward, should be summoned. She also said she remembered the five steps highlighted in the Servewise course that should be carried out if someone

appeared to collapse. Christopher Harvie also had some difficulty in his recollection of the content of any booklet. He thought he had attained bronze level but had not completed silver level. He recognised some parts of the Servewise booklet and in particular reference to the recovery position. Richard Wishart recalled receiving about two hours induction on emergency procedures before his first shift. He recalled completing a booklet but said he had not received any first aid training. Basic first aid advice had been included in the Servewise course. All said that if there was a problem with a customer who required medical attention or appeared to be intoxicated and was becoming aggressive assistance should be obtained from the door stewards.

[22] I found David Pennycook in particular an unimpressive witness. While some time has elapsed since the death of Mr Foster Mr Pennycook's apparent inability to remember the significant events of 11th June 2004 was surprising. His difficulty in remembering details of his employment with Luminar and his attempt to minimise his level of responsibility on the evening in question verged on the evasive. While Jacqueline Caldwell appeared to have a better recollection of some information acquired from Luminar her inability to remember the crucial events of 11th June 2004 was attributed to the amount of alcohol consumed by her. She maintained that she was so drunk herself that she could remember nothing from the time that Mr Foster fell asleep in the chair. She left the venue at about 4.30am intending to start her work with RS McColl at 6.30am. It was not clear whether her inability to remember the crucial events of 11th June 2004 was a matter of convenience or was indeed alcoholic amnesia. Richard Wishart seemed to have the best recollection of information such as that contained in the Servewise booklet but since he has remained in the industry and has received training from his current employers it was not clear whether his knowledge was due to recent training or to his employment with Luminar.

[23] It is not clear whether the witnesses' difficulties in recalling the content of booklets provided by Luminar or the content of any training was due to inadequacy in training, inattention to detail or the passage of time. Thomas Lang, who was also unimpressive as a witness, appeared to adopt a

very cavalier attitude towards training. He was aware of the inappropriate completion of booklets but took no action. He did not send anyone on a course unless they wanted to go. He attempted in his evidence to maintain that he operated a strict policy whereby if staff finished early they would not be allowed to remain in the premises and that only one staff drink would be allowed at the end of the evening. However, I formed the impression from the evidence of the other witnesses that it was more likely that a much more lax regime existed whereby staff were allowed to remain in the premises even if they finished work early and there was no limit to the amount of drink, including alcohol, which was permitted at the end of the evening.

[24] None of the bar staff appear to have received any specific training in first aid. Apart from the identification of first aiders and the location of first aid kits in the Award of Merit booklet and the references in the bronze level and Servewise booklets no formal training appears to have been provided. The door stewards and management were identified as the first aiders. David Pennycook was assumed to be a first aider because he was training to be a manager. A certificate of completion by him of a four day first aid course was produced (Crown production no 14). It was assumed by Luminar that he had completed the course operated by Upfront Training. A certificate to that effect was requested after Mr Foster's death. After enquiries it was ascertained that Mr Pennycook had not undertaken the course although his name had been put forward for it. He was on holiday at the time of the course. He could be considered only a first response in any medical emergency.

[25] The door stewards leave after all customers have left the venue. Accordingly it is unlikely that during the cleaning up process that any door steward will be in attendance. No door steward was present after the customers had left the venue on 11th June 2004. A member of management would be expected to be in attendance until the venue was closed. Managers are normally also trained in first aid to the required standard. The only member of management who was present was David Pennycook who was not a first aider trained to the standard required by the Health & Safety Executive. Accordingly on 11th June 2004 Luminar were in breach of their policy, and

their statutory obligation, to have a first aider trained to the appropriate standard in attendance when people, including staff, are present in any venue.

[26] From the evidence it appears that it was more common to find a customer reacting aggressively or violently to being refused more alcohol than to find someone so intoxicated as to be incapable of looking after himself and in need of medical assistance. The emphasis in the various booklets including the Servewise booklets is on the correct approach in such circumstances as a seller of alcohol. The door stewards are relied upon to deal with customers who appear to be drunk, act aggressively or violently and need to be ejected from the premises. It appears that while staff may receive some training, at least in form of the Servewise booklet, if they have any kind of problem they call for assistance from the door stewards and do not become involved themselves.

[27] That all witnesses said if it had been a customer and not Mr Foster who had acted in the manner he did that they would have called for medical assistance, either a first aider or an ambulance, suggests that they were aware of the appropriate steps to take in a medical emergency. Some regarded it as simply common sense, which it was, while others did recall the steps set out in the Servewise booklet at page 35.

[28] That they took no such steps is attributed to previous experience of Mr Foster's drinking habits. The evidence was that Mr Foster and his colleagues, including Mr Pennycook and other managers, frequently indulged in excessive drinking. Rachel Simnett described Mr Foster and herself, together with 80% of her colleagues, as "binge drinkers". Their aim was to drink as much as they could in as short a time as was available. Their normal drink was alcopops or shots but not beer because it was too much liquid to consume. Miss Caldwell described occasions when, after finishing work, they would go to a pub open from about 5am and still be drinking there at lunchtime. She drank so much alcohol after finishing work on 11th June 2004 that she has no recollection of events from about 3.50am and yet was intending to start her other job a couple of hours later.

[29] During such drinking sessions it was said that Mr Foster could fall asleep. He could become incoherent and unable to walk unaided and needed assistance to get home. One witness said he had been told by Mr Foster that on a previous occasion he had fallen asleep in a doorway and spent the night there. No one had seen him in quite the state he was in on 11th June 2004 nor had they seen him fall to the floor and remain there. No-one thought at the time that he was any worse than before and expected him to recover as he had done before. His colleagues, including Mr Pennycook, were all deluded because of previous heavy drinking sessions in which they had all indulged and which had not led to any apparent problems. As a result they took no steps to call for medical assistance and simply believed that he would be all right when he had slept it off. Mr Pennycook, as the person left in charge of the venue, has been singled out as the person who ought to have taken the appropriate steps. While one would expect a person in a managerial role to take charge he was one of the crowd who went off drinking with Mr Foster. I formed the impression that he was as influenced by his previous experiences of Mr Foster's behaviour as everyone else was.

[30] Police enquiries following Mr Foster's death resulted in a report by Lothian and Borders Police Licensing Section to the City of Edinburgh Council Licensing Board. In terms of section 31 of the Licensing (Scotland) Act 1976 the local authority has power to suspend a licence for a period of twelve months or up to the expiry of the licence if it is satisfied that the licensee is not a fit and proper person to hold a license or if it is satisfied that there is a risk to public safety. Following a hearing at which detailed submissions were made not only about the death of Mr Foster but other incidents at the venue which gave rise to concern (Crown production no) the Board decided that there was a risk to public safety and suspended the licence for a period of three months.

[31] Inspector Morton of the licensing section of Lothian and Borders Police was at pains to emphasise that there was a good relationship between the police and Luminar. The company operate a number of venues in Edinburgh. They had reacted to the concerns expressed and had put in place measures to address these. There had been no evidence of overselling. The

company had cancelled a Vodka promotion and were intending to expedite training of employees. These measures together with various other steps as set out in the submissions to the Board had satisfied the police.

[32] Mr Dennis, a founding Director of the company and although retired in March 2007 authorised to speak on behalf of the company, said that a thorough investigation had been carried out following Mr Foster's death. Changes were made in the management of the venue. A number of personnel were dismissed. Although Mr Dennis was reluctant to say so I formed the impression that if Mr Lang had not resigned disciplinary proceedings would probably have resulted in his dismissal. Instructions were issued to managers that staff should not remain within the venues if they finished their work early. After work drinks are not prohibited but all drinks permitted at the discretion of a manager must be accounted for. Regular stock checks and financial audits are carried out which would highlight any manager who was being overly generous.

[33] Mr Dennis also explained that a Light Patrol system had been introduced. At regular intervals throughout the period during which the venue was open to the public someone would be designated to go round the various parts of the premises to check that no-one was in need of assistance. The system required bar codes to be read to confirm that the area had been checked. If someone appeared to be asleep they would be checked to see if they were in need of assistance and if appropriate a first aider would be summoned. It was the responsibility of the manager in charge of the venue to designate an appropriate person to carry out this task, but, in Mr Dennis's opinion, it would need to be someone upon whom the manager could rely.

[34] Unfortunately Mr Dennis was unable to say what, if any, training was provided which would allow the person carrying out this task to recognise the difference between someone sleeping and someone in need of medical assistance. There was no evidence that any first aid training received by anyone employed at the venues included assessment of levels of consciousness or the use of the sort of painful stimuli employed by Mr Baldie. The five steps set out in the Servewise booklet presuppose a recognition that someone has "collapsed" and is in need of medical assistance.

[35] As Mr Foster senior said no-one poured the alcohol down his son's throat. He drank the amount he did voluntarily. He and his colleagues indulged in what is referred to as "binge drinking" on a regular basis. Mr Harvie took various photographs of Mr Foster while he was lying on the floor. He did not do so maliciously but because he was regarded as an object of amusement rather than someone in need of assistance. The consumption of alcohol to excess is a matter of grave public concern receiving regular press and media attention. Notwithstanding the information generally available about the dangers of excessive drinking, reinforced through the Servewise training to those in the licensed trade about the number of units of alcohol which may be consumed "safely", excessive drinking continues. No-one believes that the stories of alcohol causing ill-health, brain disease and death will ever happen to them. But it did happen to Mr Foster while his colleagues watched in ignorance.

[36] The systems and procedures operated by Luminar may be said to have been far from perfect. Mr Foster had been employed for several months before he undertook the Servewise course. There was no formal process of assessment following attendance at the course. There was confusion about Mr Pennycook's level of training as a first aider. There was no suitably qualified first aider present while staff were clearing up on 11th June 2004. Although no details were provided Luminar were clearly so dissatisfied with the performance of the management team and other personnel in the venue that certain people were dismissed and Mr Lang felt it appropriate to resign. The evidence raised questions about the suitability of Mr Pennycook in an unsupervised managerial role.

[37] However I am not satisfied that any failure or defect in Luminar's systems contributed to Mr Foster's death. The real issue in this case is the acceptance by certain people of a culture of "binge" drinking to the point of a state of collapse. As far as Mr Foster's colleagues were concerned it was acceptable for him to drink a vast quantity of alcohol in a short period of time and to become increasingly intoxicated, in the same way as it was acceptable for Miss Caldwell to become so intoxicated that she apparently suffered loss of memory. While the Light Patrols instituted by Luminar may assist in

detecting persons in their venues who may be in need of medical assistance a very high level of training will be required to ensure that the person carrying out the assessments are capable of assessing levels of consciousness. What is essential is to prevent persons reaching such a state of intoxication that they are endangering their lives, not to mention all the other unpleasant and costly consequences of excessive drinking. Sellers of alcohol are at present told that they must not serve alcohol to someone who is drunk. That of course gives rise to a conflict for companies such as Luminar who are in business to make money through the sale of alcohol. It is worthy of note that Mr Pennycook's project for his gold level award was "up selling" or boosting sales of alcohol. Mr Dennis said in his evidence that Luminar want to be a responsible retailer of alcohol and support minimum price controls. It is a matter of concern, according to figures reproduced in the Servewise booklet at page 28 and referred to by Miss Bowie from Alcohol Focus in her evidence, that the highest risk occupation for alcohol related diseases is publican or bar staff.

[38] Mr Foster's death was entirely avoidable. If other tragedies are to be avoided society must change its attitude to the consumption of alcohol to excess. Education about the harmful effects of alcohol and the unacceptability of persons in a state of intoxication must be a continuing process. The Servewise course is repeated every three years. Changes to the Servewise booklet introduced following the Determination in 2001 by Sheriff Stephen in the Inquiry into the death of John McGrady are only now being published. Such a delay in the promulgation of her recommendations for the general benefit of those involved in the sale of alcohol is regrettable. Consideration may need to be given to delivering the information contained in the Servewise course more frequently.

[39] It is for Parliament to consider what measures may contribute to social change.