

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2015] FAI 35

DETERMINATION

BY SHERIFF ANDREW CHRISTIE NORMAND

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)

ACT 1976

into the death of

IAN (FORMERLY JOHN) LOUDON

Glasgow, 14 December 2015

The Sheriff, having heard evidence and having resumed consideration of the cause, finds and determines that

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

Ian Loudon, whose date of birth was 1 August 1974, and who normally resided in Glasgow but was at the time of no fixed abode, died in Cell 38 at London Road Police Office, London Road, Glasgow between midnight and 3am on 2 November 2013.

2. In terms of section 6(1)(b) of the Act:

The cause of the death of Ian Loudon was:

1a Bronchopneumonia in association with mixed drug substance intoxication (methadone and diazepam).

3. In terms of section 6(1)(c) of the Act:

The reasonable precautions whereby the death might have been avoided were:

1. For the police to have taken Ian Loudon to hospital immediately after he had been arrested at around 8pm on 1 November 2013, as they initially set out to do.

2. For the Police Casualty Surgeon who examined Ian Loudon at London Road Police Office at 8.45pm on 1 November 2013 to have carried out an adequate and appropriate examination of Mr Loudon and to have sent him to hospital.

3. For the Police Custody and Security Officers who placed Ian Loudon in the recovery position in his cell just before midnight on 1 November 2013 to have reported the condition in which they found Mr Loudon and the action they had taken to the Duty Custody Officer and for that officer personally to have checked Mr Loudon's condition and sent him to hospital.

4. In terms of section 6(1)(d) of the Act: the defect in any system of working which contributed to the deaths:

There is no finding.

5. In terms of section 6(1)(e):

There are no other facts which are relevant to the circumstances of the death.

Andrew C Normand

Representation at the Inquiry:

For the Crown: Mrs Margaret Dunipace, Procurator Fiscal Depute ("PF")

For the family of Ian Loudon: Miss Frances Connor, Advocate

For William Anderson: Mr Michael Briggs and Ms Jillian Merchant, Solicitors

For Dr Andrew McCall: Mr James Stewart, Solicitor

For Temporary Police Inspector Stephen McLaughlin, Police Sergeant Barclay Hall and Police Constable Craig Hartley: Mr Callum Anderson and Mr Alistair Gillies, Solicitors

For the Chief Constable, Police Scotland: Miss Rhona Stannage, Solicitor

Members of Ian Loudon's family attended throughout the court hearings and conducted themselves with composure and dignity. Mr Loudon's death has understandably caused great sadness to his family. I expressed the condolences of the court to the family at the start of the Inquiry and I repeat here that expression of sympathy.

Part 1. General Legal Framework

1.1 This was an Inquiry held under section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, on the ground that the person who died was, at the time of his death, in legal custody (section 1(1)(a)(ii)).

1.2 Fatal Accident Inquiries and the procedure to be followed in the conduct of such Inquiries are governed by the provisions of the 1976 Act and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 made under section 7(1) of the Act.

1.3 Subject to the provisions of the Act and the Rules, the rules of evidence and the procedure are to be "as nearly as possible those applicable in an ordinary civil cause brought before the sheriff sitting alone" (section 4(7) of the Act). The normal civil standard of proof (the balance of probabilities) applies (section 4(7)) and corroboration is not required (section 6(2)). Hearsay evidence is admissible (section 2(1) of the Civil Evidence (Scotland) Act 1988), as is affidavit evidence (Rule 10 of the 1977 Rules), and evidence may be agreed by joint Minute of Agreement.

1.4 The purpose of an Inquiry held in terms of the 1976 Act is for the sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction:

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death;

(e) any other facts which are relevant to the circumstances of the death

- all in terms of section 6(1) of the Act.

1.5 The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and any other party if so advised (section 4). Any determination by the sheriff must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 6(1) of the Act.

1.6 As has been stated in many Fatal Accident Inquiry (“FAI”) Determinations, consideration of section 6(1)(c) involves an exercise of retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. (See, for example, Sheriff Principal Lockhart’s Determination in the “Rosepark Inquiry”, 20 April 2011 [at para. 7], in which he referred to his Determination in the Newton rail crash Inquiry in 1993.) A finding under sub-paragraph (c) requires not a probability but a “real and lively possibility” that the death might have been avoided by the reasonable precaution (Carmichael, *Sudden Deaths and Fatal Accident Inquiries* 3rd Ed at para. 5-75, using Sheriff Kearney’s expression in his Determination in the FAI in relation to the death of James McAlpine, issued on 17 January 1986.) It is not necessary for the court to be satisfied that the precaution would in fact have avoided the accident or death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one (Sheriff Kearney in his above-mentioned Determination, referred to in Carmichael at para. 8-99 and in countless other Determinations).

1.7 Section 6(3) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident resulting in the death. While this prohibition is intended to encourage a full and open exploration of the circumstances of a death it also reflects the position that an FAI is not a forum designed to establish legal fault. Nor does the

sheriff have any power to make such a finding. The position was authoritatively stated in the routinely quoted opinion of Lord President Hope in *Black v Scott Lithgow Limited* 1990 SC 322, at page 327: *"There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident."* That position was more recently confirmed by Lord President Hamilton in *Global Santa Fe Drilling v Lord Advocate* 2009 SLT 597 where at page 604 para. 28 he observed under reference to *Black v Scott Lithgow* that although the sheriff presiding at a Fatal Accident Inquiry has judicial duties he does not sit to determine the rights or obligations of parties. Thus a Fatal Accident Inquiry is more concerned with fact-finding, than fault-finding (Carmichael para. 5-63).

1.8 However, that is not to say that evidence tending to demonstrate fault may not properly be led before the Inquiry. Nor does it mean that the sheriff is precluded from making findings which may infer fault where it is proper to do so. This is important when having regard to future safety and the prevention of a recurrence of the accident or the death. In the words of Carmichael (at para. 5-76.):

"[W]here the evidence is sufficiently compelling, the responsibility of exposing and finding fault should be accepted. The whole object of impartial public inquiry is to get at the truth, to expose fault where fault is proven to exist, and in all cases to see to it so far as is humanly possible that the same mistake, when it arise through fault or any other reason, is not made in the future. The public interest, in whose name inquiries are held, requires and deserves no less."

Such a position was recognised by Lord Cullen in the course of his review of fatal accident inquiries:

"It is true that the investigation into the circumstances of a death in an FAI may disclose grounds of criticism from which a basis for alleging fault may be inferred. That may be unavoidable if the FAI is to fulfil its function of investigating the circumstances of a death." (Report of the Review of Fatal Accident Inquiry Legislation (2009) at para.3.23.)

Part 2. The Proceedings, Witnesses/Evidence

2.1 The Inquiry took place over a total of 12 days in August and September 2015, during which evidence was heard on 10 days.

2.2 Evidence was led principally by the Procurator Fiscal Depute, Mrs Dunipace, in accordance with the duty under section 4(1) of the 1976 Act. Evidence was also led on behalf of the family of Ian Loudon.

2.3 The witnesses are listed below in the order in which they gave evidence, with the exception of the family's witness, Dr Cary, whose evidence was taken for convenience before the completion of the Crown evidence.

List of witnesses:

Crown witnesses:

1. Police Constable Scott MacDowell
2. Police Constable Paul Campbell
3. Temporary Police Inspector Stephen McLaughlin
4. Dr. Kerryanne Shearer
5. Police Custody and Security Officer (PCSO) William Waters
6. PCSO William Anderson
7. Dr Andrew McCall
8. PCSO Paul Richards
9. Police Constable Craig Hartley
10. Police Sergeant Barclay Hall
11. Police Constable Audrey Morrison
12. Dr Richard Stevenson

List of witnesses continued:

Family's Witnesses:

1. Dr N R B Cary
2. Dr Colin Smith
3. Sandra Williamson (affidavit)

2.4 The Inquiry was held less than two years after the death and the recollection of events of many of the witnesses was reasonably good. Documentary evidence of records made at the time assisted recollection, although some witnesses required to rely on such

records as their memory was not clear. In the case of some witnesses their memory was assisted by reference to their statements given to the police at the time. One important witness, Dr Andrew McCall, did not remember the relevant circumstances. His evidence depended on his notes made at the time and reference was also made to his police statement. Useful CCTV evidence of Mr Loudon at London Road police office and of the cell corridor there was available to the Inquiry, but CCTV recording of Mr Loudon in his cell was not available, apparently because the recording system did not operate at the time although the cell camera and observation room screen were functioning. No explanation was provided for the failure of the recording system. Had such a recording been available it may have been of assistance to the Inquiry, but its unavailability did not adversely affect the Inquiry.

2.5 Parties lodged and circulated written submissions before the hearing on submissions held on 8 October 2015. Supplementary comments or submissions were offered orally at the hearing by some of the parties. Some of the written submissions were quite lengthy and I do not rehearse all the submissions in detail, although I refer to particular submissions where appropriate. I should state that I have given all the parties' submissions full and careful consideration, even where there is no specific reference or comment in the relevant part of my Determination.

Part 3. The Deceased, Ian (John) Loudon

3.1 Ian Loudon's name was registered at birth as "John Loudon", but he was known throughout his life as "Ian". He was a 39 year old single man at the time of his death. In his youth he was a talented football player and after leaving school he was in employment for a time. However, he became increasingly involved in drug abuse and battled addiction for over twenty years before his death. He committed a number of drug-related offences. He engaged with treatment for his addiction at various rehabilitation facilities and following

one such period of rehabilitation in 2011 he obtained his own tenancy. He continued to be prescribed methadone. Shortly before 1 November 2013 Ian Loudon returned to reside with his father at his home in Baillieston, Glasgow, after being the victim of an assault. Mr Loudon was a loving son and brother. After his mother's death in 2008, which was a grave blow to him, Ian Loudon was supported by his father and, particularly, by his sister Sandra Williamson.

Part 4. Summary of Evidence

4.1 In this section I set out a summary of the factual circumstances as I found them to be established by the evidence I heard and saw.

4.2 On Friday 1 November 2013 Ian Loudon was staying at his father's home address in Baillieston, Glasgow. He was seen at the house that day by his sister, Sandra Williamson, who thought that he looked unwell and was behaving in a way that was out of character. He told her that he had not taken any drugs.

4.3 Police were called to the house on the evening of 1 November because Mr Loudon was causing a disturbance. Mr Loudon was removed from the house at the request of his father. He walked out of his own accord. He walked in a straight line and was steady. He was not happy about having to leave, but initially was co-operative. The police would have allowed him to go on his way. However, Mr Loudon became angry, refused to leave the scene, shouted about his father being a "grass", swore and threatened to kick the door after the police left. He was therefore arrested by the officers, witnesses Police Constables Scott MacDowell and Paul Campbell, at around 8pm outside the house for a contravention of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010. After his arrest Mr Loudon told the police officers that he had smoked heroin and used valium and he appeared to be under the influence of a substance.

4.4 When a police vehicle was summoned to take the officers and Mr Loudon to London Road Police Office the officers were concerned about his condition and it was initially arranged that he would be taken directly to Glasgow Royal Infirmary for examination.

However, while the vehicle was en route to Glasgow Royal Infirmary that arrangement was changed by the Custody Sergeant on duty at London Road Police Office, Sergeant Stephen McLaughlin. Sergeant McLaughlin instructed that Mr Loudon should be brought directly to the police station as a Police Casualty Surgeon, Dr Andrew McCall, was at the police station and Mr Loudon could be medically examined soon after his arrival at the police station, rather than having to wait to be seen at Glasgow Royal Infirmary where delay could usually be expected in the A&E department on a Friday night. Such delay would also remove the two police officers from active duty for an unknown period. Sergeant McLaughlin's intention was that Mr Loudon should be seen by Dr McCall after being processed on arrival at the police office.

4.5 On arrival at London Road Police Office Mr Loudon was initially detained in a holding cell before being presented to Sergeant McLaughlin at the charge bar. In the holding cell Mr Loudon was drowsy, at times slumping over while sitting on the bench causing one of the officers to support him. When taken to the charge bar and presented to Sergeant McLaughlin Mr Loudon was able to walk, albeit that he was escorted by an officer on either side. He was processed in the usual way, including being asked a series of questions to which he gave replies, providing his personal details and answers to questions set out in the police custody record Care Plan (Production 4). Mr Loudon's level of alertness fluctuated and at times he appeared to be drowsy. Sergeant McLaughlin gained his attention by shouting at him or hitting the desk.

4.6 In his answers to Care Plan questions Mr Loudon disclosed that he had used drugs in the last 24 hours – he said valium – and he was suffering from or had in the past suffered from withdrawal symptoms from drug and alcohol withdrawals. He had attempted self-harm or suicide, by cutting his wrists 3 months ago. He replied “yes”, when asked “Do you have any thoughts at this time of self-harm or suicide?” This caused Sergeant McLaughlin to decide that Mr Loudon should be placed in a cell where he could be kept under constant observation. Sergeant McLaughlin also decided that Mr Loudon should be visited in his cell once per hour. This is the minimum frequency of visits to custodies required by the Police Scotland “Standing Operating Procedures” for “Care and Welfare of Persons in Police

Custody” (Production 14), which are designed to provide guidance and direction to officers involved in care of prisoners while in custody. This statement of procedures applied to Mr Loudon’s detention in custody.

4.7 On Sergeant McLaughlin’s instruction Mr Loudon was taken immediately thereafter to be examined by the Police Casualty Surgeon, Dr Andrew McCall, in the nearby medical room. He walked from the charge bar to the medical room with an officer on either side. After an examination that took less than 2 minutes Dr McCall – whose report of his examination (Production 7) showed the time of examination as 2045 – certified Mr Loudon as being fit to be detained and instructed that he be placed in an observation cell, with routine hourly checks. The report recorded that Mr Loudon was intoxicated, that he had thoughts of self-harm, that he was on cocaine, heroin, alcohol and valium. Dr McCall carried out a number of tests, but did not carry out a full range of potentially relevant tests.

4.8 After the examination by Dr McCall, Mr Loudon was taken to observation cell 38 via the charge bar where he was searched. He walked from the medical room to the cell (via the charge bar) accompanied by two custody officers, each of whom had hold of an arm. He stood in the cell.

4.9 The nightshift Custody Sergeant was Police Sergeant Barclay Hall, who took over from Sergeant McLaughlin at around 9 pm. Sergeant Hall then had overall responsibility for prisoners in custody at London Road Police Office that night.

4.10 Police Custody and Security Officers on duty were PCSO William Anderson and PCSO Paul Richards. They had responsibility for carrying out the hourly checks on Ian Loudon after Sergeant Hall made a tour of the cells and checked all the prisoners around 9pm, when the sergeant commenced duty. When Sergeant Hall checked Ian Loudon he saw Mr Loudon standing unsteadily in his cell. Mr Loudon confirmed he was ok, asked in a jokey way for a “smoke” and gave his name. Sergeant Hall did not pay any subsequent visit to Mr Loudon’s cell.

4.11 The routine procedure for the prisoner checks was to open the cell-door hatch, speak (or shout) to the prisoner and get a positive, verbal response. PCSO Richards carried out a

check at 10pm. The 11pm check was done by PCSO Anderson. Just before midnight (at 11.59pm) PCSO Richards got no verbal response when he shouted to Mr Loudon from the hatch. He opened the door and saw Mr Loudon sitting slumped in the corner of the cell. PCSO Richards called for assistance from PCSO Anderson. The two officers laid Mr Loudon down on the bed in the recovery position, to make him more comfortable and prevent choking. Mr Loudon was breathing, groaning and muttering when this was done. The officers did not get a clear verbal response from Mr Loudon at any time during this procedure. No information was recorded under the "Remarks" heading in the custody record about the placing of Mr Loudon in the recovery position at this visit, although the visit itself was recorded. Sergeant Hall was not told of this action or that there had been no clear verbal response from Mr Loudon. Had he been told he would have visited Mr Loudon himself and sent him to hospital if he had been unable to rouse him and obtain a clear verbal response.

4.12 PCSO Richards carried out the cell check at 1am on 2 November. In respect of all of the foregoing visits one of the two PCSOs (although not necessarily the officer who actually carried out the visit) entered in the visit details part of the custody record (Production 4) the time of the visit and a code number indicating that Mr Loudon was awake and responded. No check was carried out at 2am. PCSO Anderson went to the cell door to carry out the check, but he was called away before doing it and neither he nor PCSO Richards thereafter carried out the check that was due at that time. However, PCSO Richards recorded a visit at 2.05am in the custody record.

4.13 From the time Mr Loudon was placed in Cell 38 until about 1.50am the camera image from the cell was observed by PC MacDowell on a screen in a nearby observation room. The screen showed images from up to four cells at the same time. PC MacDowell did not have a clear view of Mr Loudon in the cell. The lighting in the cell was poor. It would only have been possible to see movement such as the prisoner using the toilet, being sick or self-harming. PC MacDowell was not able to determine Mr Loudon's breathing or level of consciousness from what was shown by the camera on the screen. Mr Loudon's right arm moved occasionally from soon after he was placed in the cell. It looked like he was sleeping.

After PC MacDowell saw the PCSOs put Mr Loudon in the recovery position he saw Mr Loudon's right hand move slightly. He appeared to be in a deep sleep.

4.14 PC Hartley took over observation from PC MacDowell at the time recorded as 1.44am. The screen image of Mr Loudon in the cell was not clear. It would only have been possible to see movement such as the prisoner using the toilet, standing up, being sick or self-harming. PC Hartley was not able to see if Mr Loudon was breathing from what was shown by the camera on the screen. PC Hartley saw no movement from Mr Loudon in the cell.

4.15 At 3am PCSO Anderson went to the door of Mr Loudon's cell to carry out the hourly check. There was no response when he shouted. He looked in and observed a small pool of vomit by Mr Loudon's head. Mr Loudon was lying in the same position as he had been placed in earlier. PCSO Anderson went into the cell. There was no reply. Mr Loudon was not breathing and PCSO Anderson could not find a pulse. PCSO Anderson called for assistance. Sergeant Hall attended at the cell. He saw that Mr Loudon was not breathing and his eyes were open. A call was made for an ambulance. PC Audrey Morrison also attended and saw that Mr Loudon was not breathing. She carried out CPR until the ambulance arrived. Mr Loudon did not respond. PC Morrison never saw Mr Loudon's chest rise. Mr Loudon's skin still felt warm.

4.16 An ambulance arrived at about 3.10am. A paramedic took over examination of Mr Houston and got no response. No pulse was found. Mr Loudon was placed in the ambulance and taken to Glasgow Royal Infirmary where he was admitted at 3.25am. He was examined by Dr Richard Stevenson, Consultant in Accident and Emergency Medicine. Attempts were made to resuscitate Mr Loudon, but these were unsuccessful and life was pronounced extinct at 3.45am on 2 November 2013.

Part 5. Section 6(1)(a): Where and when the death took place

5.1 As noted above, Ian Loudon was found in Cell 38 at London Road Police Office at 3am on 2 November 2013 not breathing and unresponsive. He was taken by ambulance to Glasgow Royal Infirmary where, after unsuccessful attempts to resuscitate him, life was pronounced extinct at 3.45am.

5.2 All the witnesses who entered Mr Loudon's cell at 3am gave evidence that Mr Loudon was not breathing. He did not respond to CPR. No pulse was found. Dr Stevenson, speaking to the hospital medical records (Production 13), gave evidence that on arrival at the hospital Mr Loudon was not breathing and had no vital signs. There was no pulse, no heart activity. The result of a test that was carried out immediately was not compatible with life. Asked by Miss Stannage if he thought Mr Loudon had been dead for some time when he saw him Dr Stevenson replied that he could not say for how long. I understood his response to a supplementary question to be that Mr Loudon had been "*in extremis*" for at least an hour.

5.3 The evidence of Constable Audrey Morrison, who carried out CPR, was that Mr Loudon's skin still felt warm. The pathologist, Dr Shearer, was asked by Mr Anderson about the relevance of body temperature in relation to determining the time of death. Asked about the time of death if the body was still warm when found to be unresponsive, Dr Shearer stated that that would normally mean that the person had died two to three hours before he was found. I noted Dr Cary's statement about timing of death in his report, which was evidence in the Inquiry (Family Production 1). He said (in paragraph 8): "In relation to timing of death all that can be said is that it must have occurred at some time after being reliably determined to have been alive i.e. through the eliciting of a meaningful response and when discovered to be dead."

Submissions

5.4 Parties' submissions were equally divided between those that invited me to determine that the place of death was Glasgow Royal Infirmary and those that invited me to find that the place of death was Cell 38 at London Road Police Office. The submissions of the PF, Ms Merchant and Miss Stannage proposed the former. Only Miss Stannage supported her submission by advancing any specific argument. She suggested that as it was impossible

to give a precise time of death in this case it would be appropriate for me to determine that death occurred when life was pronounced extinct, which was at the hospital at 3.45am.

5.5 Miss Connor, Mr Stewart and Mr Anderson submitted that I should find that the place of death was Cell 38 at London Road Police Station (or “Police Office” in Mr Anderson’s description). Miss Connor suggested that the time be recorded as “between the hours of 00.00 and 03.00 hours”. Mr Stewart submitted that the time of death must lie between approximately 00.20 and 03.00, the former time being “the last time it can be stated with certainty that Mr Loudon was alive” and 03.00 being when he was discovered in his cell. Mr Stewart suggested that all the witnesses who entered the cell and who spoke on the point gave evidence that in their view Mr Loudon was dead when they entered the cell at 03.00, and his understanding of Dr Stevenson’s evidence was that Mr Loudon was dead on his arrival at the hospital. Mr Anderson’s submission was that the death occurred in Cell 38 between 0105hrs and 0345hrs. No further argument was advanced in support of this submission.

Discussion and determination

5.6 On my view of the evidence I accept the submissions that the place of death was Cell 38 at London Road Police Office. In addition to the evidence of the witnesses who attended at the cell I interpreted Dr Stevenson’s evidence to be that Mr Loudon was dead on arrival at the hospital. As regards the time of death it was clearly therefore before 3am. On the evidence it is only possible to state a period within which death occurred. I do not agree with Miss Stannage’s submission noted above. In my view it is perfectly competent and appropriate to state that death occurred during a specified period, rather than at a “precise time”.

5.7 It appears that the approach of Miss Connor, as well as of Mr Stewart, is based on the proposition that the episode at midnight when the PCSOs placed Mr Loudon in the recovery position is the last time it can be stated with certainty that Mr Loudon was alive, although I am unclear about Mr Stewart’s precise choice of the time of “00.20”, as I could not find a reference to that in the evidence. Acceptance of the time period proposed by Miss Connor

and Mr Stewart would involve an inference that Mr Loudon may have been dead at 1am, when there is evidence that PCSO Paul Richards carried out a prisoner cell check.

5.8 Miss Stannage submitted that “Mr Richards gave evidence that when he visited Mr. Loudon at 1am he obtained a response from him.” She suggested that I should accept that evidence, arguing that Mr. Richards gave his evidence in a very straightforward, believable way, that his evidence was supported by the CCTV footage of this visit, and by the fact that at this visit Mr Richards did not require to enter Mr. Loudon’s cell as he did at midnight.

5.9 In fact I do not have a record of clear evidence from Mr Richards that he visited Mr Loudon at 1am and obtained a response from him. What I have is a record that when Mr Richards was first asked by the PF about the 1am cell check he said he could not remember if he did that visit. In cross examination by Miss Connor about the record of visits (in Production 4) he said: “from this it looks like I have done 10pm, 12, 1 and 2”. In fact the CCTV recording does show that it was Mr Richards who went to the door of Mr Loudon’s cell at 1am and shouted “ok, pal?” It does not record that PCSO Richards got a verbal response from Mr Loudon. The only passage of evidence that I can find in which there is reference to PCSO Richards receiving a response is when Mr Richards was asked the following question by Miss Stannage: “At the visit at 1am by you, you did not enter the cell. I take it that if you did not enter you must have received a response that satisfied you?” Mr Richards replied: “Yes”. Such evidence is of very limited value, particularly in the context of initial evidence that the witness did not remember the visit.

5.10 PCSO Richards failed to get a verbal response from Mr Loudon when he shouted and rattled the door at midnight and his evidence about moving Mr Loudon at midnight was that Mr Loudon seemed in a “deep, heavy sleep”. PC MacDowell was carrying out CCTV link observation of the cell until 1.50am. He saw the PCSOs enter the cell at midnight and place Mr Loudon in the recovery position. His evidence was that after that it looked like Mr Loudon was in a deep sleep. The only movement which he observed was a slight hand movement by Mr Loudon, but I understood him to say that this was just after Mr Loudon was moved into the recovery position. He was not asked specifically about the check at 1am. PC Hartley (who took over observation at 1.50am) observed no movement

from Mr Loudon, who remained lying on his side in the recovery position in which PC Hartley was told he had been placed.

5.11 I am not satisfied that PCSO Richards' evidence and the CCTV evidence provide clear evidence that Mr Loudon was alive at 1am. Mr Loudon may have been alive at 1am, but I do not consider that it is possible to be satisfied on the evidence that he definitely was alive at that time. I believe the evidence I heard and saw supports a conclusion that the episode at midnight when the PCSOs placed Mr Loudon in the recovery position is (as Mr Stewart put it) "the last time it can be stated with certainty that Mr Loudon was alive". I have also noted above Dr Shearer's evidence about the time of death if the body was still warm when the deceased was found to be unresponsive. Whether that evidence is interpreted as indicating an actual time of death or a possible time frame during which death may have occurred before the finding of the body it would not be inconsistent with the possible time of Mr Loudon's death being during the period between midnight and 3am.

5.12 Consequently my determination in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is:

Ian Loudon, date of birth 1 August 1974, who normally resided in Glasgow but was at the time of no fixed abode, died in Cell 38 at London Road Police Office, London Road, Glasgow between midnight and 3am on 2 November 2013.

Part 6. Section 6(1)(b): The cause of the death

6.1 Unusually in a case such as this the cause of death that was initially given by the pathologists who carried out the post mortem examination of Ian Loudon on the instructions of the Procurator Fiscal was: "Unascertained". The post mortem was carried out on 3 November 2013 at the Southern General Hospital, Glasgow by Dr Kerryanne Shearer and Dr Julie Adams, who were both at the time Forensic Pathologists at Glasgow University. Their Post Mortem Report (Production 2) was dated 13 December 2013. Attached to the report was a supplementary report dated 23 December 2013 by Dr Colin Smith, Consultant Neuropathologist at the Division of Pathology Forensic Medicine,

University of Edinburgh.

6.2 In the Conclusions section of their Post Mortem Report, Dr Kerryanne Shearer and Dr Julie Adams stated: "This is a very complex case". They concluded this section of their report by stating: "Overall, taking everything into consideration it is not possible to be certain of a definite cause of death in this case and as such the cause of death will remain unascertained."

6.3 The lead pathologist, Dr Kerryanne Shearer, gave evidence at the Inquiry. She adhered to the above-mentioned opinion and explained why she reached it, referring to a number of factors that "muddied the waters" and meant that she "could not be 100% sure that this was a drug-related death". One of the main factors was information that had been provided to her and her colleague that Mr Loudon had been verbalising a relatively short time before he was found unresponsive and not breathing in his cell. In her evidence Dr Shearer referred to Mr Loudon speaking an hour before he was found. She said that if Mr Loudon actually spoke and did not just grunt or snore, "this was one of the main things that muddled the waters". The post mortem report refers to Mr Loudon being "rousable at 23.00 or 00.00 hours" and mumbling a verbal response when placed in the recovery position at 2300hrs or 0000hrs. This was further explored in cross-examination by Miss Connor when Dr Shearer said that she had interpreted the information provided to her and recorded in her report to mean that Mr Loudon had said something understandable. It would not be sufficient if he grunted or moaned as that would indicate that he was becoming less and less alert.

6.4 Dr Shearer stated in evidence that if she had the case "without the background factors" she would have had "no hesitation in certifying it as a drugs death." However, in any event Dr Shearer stated – and confirmed to the court – that her opinion was that on a balance of probabilities the cause of death was drug-related. She said that she would be even more sure in that opinion if there was doubt about whether as a matter of fact Mr Loudon when in the cell did respond to police staff by saying something understandable, as she put it. She would state the cause of death on the balance of probabilities as: "Combined mixed drug intoxication (methadone, diazepam, etc.)"

6.5 In the course of her evidence in chief about the post mortem findings described in her report Dr Shearer commented that there were no gross findings of infection and that she would have expected to see a lot more if infection was relevant to the cause of death. In her view pneumonia was not a significant factor in Mr Loudon's death. A small finding of pneumonia was something that she regularly finds in drug-related deaths. However, in cross examination by Miss Connor Dr Shearer agreed that if this was simply a drug-related death there would not be hypoglycaemia and petechial haemorrhages on the brain, such as were found here. Dr Shearer was asked to comment on the cause of death suggested by the pathologist who was called as a witness for the family, Dr N R B Cary. For reasons that included her view that bronchopneumonia was not present to the extent that it would necessarily cause sepsis and there was no other finding of sepsis, Dr Shearer preferred the conclusion that on a balance of probabilities the cause of death was drug-related. In response to my question seeking clarification in that regards, Dr Shearer stated that the cause of death on that basis would be "Combined mixed drug intoxication (methadone, diazepam, etc.)" I noted that Dr Shearer and Dr Adams reported in their post mortem report that the lack of information about Mr Loudon's clinical state in the hours following his incarceration and the fact that he apparently made a verbal response at 2300 or 0000 hours made it difficult to be certain that death was from "a combination of methadone, morphine, diazepam, phanezapam and buprenorphine intoxication" (Production 2 page 8).

6.6 As noted, Miss Connor for the family called as a witness Dr N R B Cary, who is a Consultant Forensic Pathologist with Forensic Pathology Services, of Wantage, Oxfordshire, and is based at Norwich. Dr Cary is a highly qualified and very experienced forensic pathologist who has served as a registered Home Office Forensic Pathologist for 22 years. He is an examiner for the Royal College of Pathologists. His experience includes experience as a Police Surgeon earlier in his career and substantial experience of giving evidence as an expert witness. He has specialised in lung pathology and diseases of the heart.

6.7 Dr Cary stated as his opinion in his report (Family Production 1) and in his evidence to the Inquiry that the cause in death in this case, based on all the findings, would be best recorded as "1a Bronchopneumia in association with mixed drug substance intoxication

(methadone and diazepam)". He explained the reasons for this conclusion, referring in particular to what he identified as "two major relevant pathological diagnoses [that were] apparent:- firstly the finding of bronchopneumonia on microscopy of the lungs and secondly the finding of mixed drug intoxication on toxicological analysis of samples taken at post mortem." He stated that bronchopneumonia was a potential cause of death of itself, particularly in a man of poor health due to chronic effects of alcohol abuse, drug abuse and hepatitis C carriage – as was the case with Mr Loudon. Dr Cary drew attention to other important findings on presentation to hospital, namely markedly raised C-reactive protein, a raised white cell count and hypoglycaemia. This led him to the opinion that "the most likely explanation for this constellation of findings is that the deceased was suffering from septic shock, which is a potential complication of acute bronchopneumonia, the latter a fairly common finding in those who become drug intoxicated and are vulnerable either to hypoventilation or postural asphyxia or a degree of aspiration of gastric contents."

6.8 In his evidence Dr Cary suggested that the recording of the cause of death as "unascertained" in this police custody death was surprising. He commented that he had never given that cause where there were clear pathological findings and remarked that as a pathologist you are expected to give your opinion. The statement at the end of the Post Mortem Report: "it is not possible to be certain of a definite cause of death in this case" – was flawed in his view. He pointed out that the test is the balance of probabilities. His opinion about the cause of death was given on that basis.

6.9 The evidence of Dr Richard Stevenson, the Consultant who was the senior medical officer involved in examining Mr Loudon on his arrival at the Accident and Emergency Department at Glasgow Royal Infirmary at 3am on 2 November 2013, included evidence that there was a very low level of blood sugar in Mr Loudon's body on examination at the hospital, suggesting that there was in fact no glucose in his body. There was also evidence of infection. Dr Stevenson was asked for his view of the cause of death. He stated his opinion, while qualifying that statement by acknowledging that he was not an expert pathologist. His opinion was that the cause of death was hypoglycaemia, probably caused by Mr Loudon's lifestyle, hepatitis C, poor nutrition not enabling him to fight off infection,

the presence of which was indicated by the results of various tests he carried out. Regarding the pathologists' findings and reports, of which he was aware, he said that in relation to bronchopneumonia in his opinion Mr Loudon would have had that and that could have been the cause of the hypoglycaemia.

6.10 The Consultant Neuropathologist who examined Mr Loudon's brain at the request of Dr Shearer and issued a report on 23 December 2013 was Dr Colin Wilson, Professor of Neuropathology at Edinburgh University. He was called as a witness by Miss Connor, for Ian Loudon's family. He gave evidence about his report, which was incorporated with the Post Mortem report in Production 2. The particular feature of his findings to which he drew attention was the petechial haemorrhages scattered throughout the cerebrum, cerebellum and brain stem. He explained possible causes and excluded many of them on the basis of his examination. Asked to comment on the blood findings recorded on admission to Accident and Emergency at Glasgow Royal Infirmary, he commented that they included important markers of sepsis. The petechial haemorrhages which he found could have been caused by sepsis resulting from infection. Dr Wilson had seen Dr Cary's report (Family Production 1) and when asked if his findings were consistent with Dr Cary's opinion about the cause of death (in paragraph 6 of his report) he stated that all the brain findings were consistent with sepsis caused by bronchopneumonia. He agreed with the fuller opinion stated by Dr Cary in paragraph 3 of his report. Asked to comment on Dr Stevenson's opinion about hypoglycaemia as the cause of death Dr Wilson gave as his opinion that in this case hypoglycaemia was caused by infection, which was the cause of death, rather than hypoglycaemia as such. He commented that while he did not dispute Dr Stevenson's opinion he thought Dr Cary's opinion about the cause of death was correct in this setting.

Submissions

6.11 Both the PF and Mr Stewart, for Dr McCall, invited me to prefer Dr Shearer's evidence and conclusion. On the basis of her review and analysis of the evidence, the PF expressed the view that the cause of death should remain as "1a unascertained". Mr Stewart submitted that I should find the cause of death to be "unascertained" as per Dr Shearer's report.

6.12 Miss Connor, in her detailed submissions for the family, sought to persuade me that Dr Cary was correct in his determination of the cause of Mr Loudon's death – namely that the cause was "1(a) Bronchopneumonia in association with mixed drug substance intoxication (methadone and diazepam)".

6.13 Ms Merchant, for William Anderson, also submitted that Mr Loudon died as a result of "(a) Bronchopneumonia and (b) Mixed drug substance intoxication". After a careful and detailed analysis of the relevant evidence, Ms Merchant submitted that taking all the evidence together I could make a finding "that Mr Loudon died as a result of bronchopneumonia, an infection which caused septic shock, resulting in brain haemorrhages and brain swelling, resulting in cardiac arrest." She went on to submit that "given that it is likely that drug intoxication also played a part in Mr Loudon's death,...this should also be noted."

6.14 For the police officers, McLaughlin, Hall and Hartley, Mr Anderson submitted that I could find the cause of death as unascertained, given the conflicting opinions of Drs Shearer and Cary, but that if I decided not to make such a finding, the opinion of Dr Cary should be preferred.

6.15 Following her analysis of the evidence Miss Stannage commented on the difficulty for the court in coming to a conclusion regarding the cause of Mr Loudon's death, but she went on to submit, on balance, that I should include a finding regarding both bronchopneumonia and mixed drug intoxication, and that I may wish to include a determination regarding petechial brain haemorrhages and brain swelling.

Discussion and Determination

6.16 I have concluded that the evidence that I heard makes it possible to make a finding on a balance of probabilities about an actual cause of death, rather than that the cause of death was "unascertained", as was originally certified and stated in the post mortem report. I am therefore not inclined to follow the submissions of the PF and Mr Stewart. Where there is evidence to allow a cause of death to be recorded on the basis that it can be established on a balance of probabilities, making such a finding is justifiable in law and is preferable in my

view to recording that the cause is “unascertained”. I note that the Crown pathologist, Dr Shearer, was in fact prepared to express an opinion about a specific cause on a balance of probabilities basis. However, differing opinions were expressed about the exact cause, albeit that there were some elements that were common to some of the opinions. I have considered whether the revised position of Dr Shearer, as the pathologist who carried out the post mortem, should be accepted. However, the weight of expert medical opinion in my view supported the cause stated by Dr Cary, and there appeared to be more difficulty in accommodating certain of the significant findings in Dr Shearer’s suggested cause. I also agree with the submission that Dr Cary was at no significant disadvantage in not having conducted the autopsy, as the relevant material was available to him, including microscopy of the lungs.

6.17 I have reached the view that I should accept the cause stated by Dr Cary, which was accepted by Dr Wilson and includes the element of drug intoxication which featured in Dr Shearer’s opinion. Although Dr Stevenson’s opinion (which he accepted was not the opinion of an expert pathologist) was that the cause of death was hypoglycaemia, his evidence that in his opinion Mr Loudon would have had bronchopneumonia and that could have been the cause of the hypoglycaemia is supportive to that extent of Dr Cary’s conclusion as to cause of death. While I accept the evidence about hypoglycaemia, petechial brain haemorrhages and brain swelling, taking account of Dr Wilson’s evidence I do not think that these need to feature in the stated cause of death.

I therefore determine that the cause of death was:

1(a) Bronchopneumonia in association with mixed drug substance intoxication (methadone and diazepam).

Part 7. Section 6(1)(c) of the Act: The reasonable precautions whereby the death might have been avoided.

Introduction

7.1 There are two essential questions that require to be addressed before any positive finding can be made under Section 6(1)(c) of the Act. They are the question of whether any

reasonable precautions existed and the question of whether the death may have been avoided by the adoption of any such precautions.

7.2 My consideration of the evidence and of the submissions suggests that the question of reasonable precautions whereby Mr Loudon's death might have been avoided may be approached by considering several particular points or stages during the period of Mr Loudon's detention in police custody. The parties' submissions to varying extents followed the approach of examining the various different stages of Mr Loudon's detention, actions taken and possible alternative actions. Some of the submissions also addressed the question of whether Mr Loudon's death might have been avoided by other action being taken. I propose to set out parties' principal submissions at this point. I do not set out all the supporting arguments advanced by the parties, but I have given consideration to those and where appropriate I shall make reference to them in my discussion below.

Submissions

7.3 The Procurator Fiscal and Ms Connor for the family made submissions inviting me to make findings about reasonable precautions that could have been taken which might have resulted in the death being avoided. Those representing all the other parties submitted that in respect of their particular clients no such findings should be made.

7.4 The PF submitted that I should find that a reasonable precaution whereby the death might have been avoided would have been "for Dr Andrew McCall, in his role as Police Casualty Surgeon, to have carried out an appropriate and adequate medical examination on Mr Loudon".

7.5 Detailed submissions were presented on behalf of the family of Mr Loudon by Miss Connor. These were prefaced by the following statement:

"If your Lordship accepts that Mr Ian Loudon was seriously unwell at the time he was detained in custody, it is respectfully submitted that the questions for your Lordship are:

Why was medical treatment not sought for Ian Loudon immediately by the police?

Why was he declared fit to be detained?

Why was his condition not adequately reviewed at appropriate intervals during his detention?

Why was medical help not sought when he could not be roused at various intervals?

The family of Ian Louden consider that significant responsibility attaches to the failings of Dr McCall. However, it is apparent from the evidence the Inquiry has heard that at various stages steps could have been taken by others which would have:

- (i) ensured Mr Louden received appropriate medical attention at an early stage
- (ii) resulted in Mr Louden's deteriorating medical condition becoming known and medical attention being obtained for him;
- (iii) prevented his death.

This leads to the reasonable precautions that could have been taken."

7.6 The detailed submissions about reasonable precautions were in the following terms:

"The family of Ian Louden consider that the following reasonable precautions, if taken by Dr McCall would have avoided the death of Ian Louden on 2 November 2013:

- (i) Carrying out a basic medical health assessment of Ian Louden before declaring him fit to be detained.
- (ii) Referring him for a medical assessment at a hospital where appropriate equipment would have been available to properly assess Mr Louden.
- (iii) Not declaring Mr Louden fit to be detained in police custody.

The family of Ian Louden consider that the following reasonable precautions, if taken by Police Constables Scott MacDowall and Paul Campbell would have avoided the deaths of Ian Louden on 2nd November 2013:

- (i) Transporting Mr Louden directly to the nearest hospital as soon as they had concerns over his health and formed the opinion he required medical treatment.

The family of Ian Louden consider that the following reasonable precautions, if taken by Sergeant Stephen McLaughlin, would have avoided the death of Ian Louden on 2nd November 2013:

- (i) recognising that Ian Louden was clearly not fit to be detained in custody and directing that he be transported to hospital immediately or by immediately summoning an ambulance to transport him to hospital.
- (ii) Recognising that a person who appears to be intoxicated may be suffering from a serious medical condition and be in need of immediate medical treatment.
- (iii) appreciating that in determining the necessity to transport directly to hospital, and in the context of determining fitness to be detained it is important not to simply rely on what the prisoner says he may have taken or how he feels;
- (iv) Appreciating that the wound to Ian Louden's hand required medical attention and in itself rendered him unfit to be detained.

- (v) appreciating that, given how Ian Loudon presented at the charge bar, Dr McCall could not have properly assessed him as being fit to be detained in the time taken.
- (vi) Appreciating that from his report (crown production 7) Dr McCall could not have conducted the necessary medical assessment of Ian Loudon required, by the lack of note of any injuries to Ian Loudon by Dr McCall, including the injury to his hand and his failure to correctly note his first name and noting of his address as "67 slurred."
- (vii) Failing to direct that Ian Loudon should be checked at more frequent intervals than the minimum required.
- (viii) Failing to alert the incoming Custody Supervising Officer – Sergeant Hall and the PCSO staff – Mr Anderson and Mr Richards of the circumstances of Mr Loudon's arrest and presentation in the holding cell and charge bar.

The family of Ian Loudon consider that the following reasonable precautions, if taken by the custody staff would have avoided the death of Ian Loudon on 2 November 2013:

- (i) carry out adequate checks on Ian Loudon at appropriate intervals
- (ii) recognise that someone who appears intoxicated may be suffering from a serious medical condition and require urgent medical treatment.
- (iii) Summon urgent medical help when Ian Loudon could not be roused at the check conducted at 2300 hours when staff placed him in the recovery position or transport him to a hospital for assessment.
- (iv) Recognize that a person who has failed to move for an extended period may be in need of urgent medical treatment."

7.7 As I have noted, all the other parties' representatives submitted in respect of their particular clients that no findings should be made about reasonable precautions that could have been taken by their clients. I shall set out the submissions of those representing the other parties in the order in which they were made, reflecting the order of representation rather than the order of parties' involvement in events.

7.8 The submission of Ms Merchant on behalf of Police Custody and Security Officer William Anderson was that there were no reasonable precautions Mr Anderson could have taken whereby the death of Mr Loudon could have been avoided. Ms Merchant focussed in particular on Mr Anderson's failure to carry out the hourly check at 2am, but she also submitted that Mr Anderson's action (along with PCSO Richards) in placing Mr Loudon in the recovery position at about midnight was reasonable in the circumstances. In relation to the failure to carry out the 2am check she submitted:

“It is submitted that one cannot determine from the evidence before the Court that there was a real and lively possibility that the death may have been avoided. ... (I)t is not possible, at least to the required degree, to assert that there is a causal link between the failure of Mr Anderson to carry out the 2am check and Mr Loudon’s death. One can only speculate about what condition Mr Loudon may have been in at the 2am check and what may or may not have happened at that point in time. We do not know and have no way of knowing with any certainty, what would have occurred had Mr Anderson carried out the 2am check. In particular there is no evidence from which to suggest that had the 2am been carried out Mr Loudon’s death might have been avoided.”

7.9 Mr Stewart submitted in respect of his client, Dr Andrew McCall, that there were no reasonable precautions that could have been undertaken by Dr McCall whereby the death might have been avoided. Among his submissions Mr Stewart invited me (by reference to evidence to which he drew my attention) to find that “at the time of the assessment Mr Loudon was presenting as an individual under the influence of drink or drugs, but not to such an extent that hospital admission was required at that time”. He submitted that it was “important to bear in mind the evidence the court heard from both medical and police witnesses that Mr Loudon’s presentation was entirely consistent with him being intoxicated” and he suggested that it was entirely possible that Mr Loudon’s presentation was due to the drugs he had taken that day.

7.10 In inviting me to refrain from making a determination under this section concerning Dr McCall’s examination of Mr Loudon, Mr Stewart drew my attention to Sheriff Braid’s determination in the FAI into the death of Marianne Bellfield (March 2011) in which the sheriff made observations about the exercise of clinical judgement by a doctor in circumstances where a range of reasonable actions might have been taken, and expressed the opinion that “a fatal accident inquiry cannot prescribe how doctors or nurses should exercise their judgement”.

7.11 In relation to the question of a real and lively possibility that a precaution might have avoided the death Mr Stewart suggested that because the cause of death was not clear that would make it difficult for the court to make a finding in terms of section 6(1)(c). He further suggested that it could not be said “with certainty” that the admission of Mr Loudon to hospital after his examination by Dr McCall might have avoided the death.

7.12 Mr Anderson for the police officers McLaughlin, Hall, and Hartley presented submissions that were later supplemented by a response to submissions of other parties, consisting of comments in response to the submissions on behalf of the family of Ian Loudon. Mr Anderson's essential submission was that there were no reasonable precautions whereby the death might have been avoided. In support of that submission he considered and commented on his clients' involvement and actions at various stages of Mr Loudon's detention in custody. I do not set those out here, but as I have indicated above I shall deal with any particular arguments below if I consider them relevant.

7.13 Ms Stannage's submission on behalf of the Chief Constable was:

"In my submission there is not sufficient evidence to support a finding that there were reasonable precautions that could have been taken by officers of Police Scotland that might have prevented Mr. Loudon's death."

That general submission was supported by further specific submissions about particular stages of Mr Loudon's detention and actions of police and custody officers. These included submissions that there was not sufficient evidence to allow findings that different actions at particular times would have avoided Mr Loudon's death.

Discussion and Findings

7.14 I have mentioned the adoption of an approach to the question of reasonable precautions whereby the death might have been avoided by examining particular points or stages during the period of Mr Loudon's detention in police custody. My view, having regard to the evidence and taking account of the parties' submissions, is that the most significant of these were:

1. The point at which the original decision to take Mr Loudon directly to hospital was changed and Mr Loudon was taken instead to London Road Police Office.
2. The point when Mr Loudon was examined by the Police Casualty Surgeon, Dr McCall.
3. The point when at the custody officer's midnight check PCSO Richards got no verbal response when he shouted to Mr Loudon from the cell hatch, then entered the cell,

found Mr Loudon sitting slumped in the corner of the cell, and with the assistance of PCSO Anderson laid Mr Loudon down on the bed in the cell in the recovery position.

4. The point when PCSO Anderson failed to carry out the 2am prisoner check at Mr Loudon's cell.

7.15 However, whether it is relevant under the section 6(1)(c) heading to scrutinise any or all of these matters – or other matters raised in submissions – is in my view dependent on the outcome of consideration of another crucial issue. That is the question of the prospect of Mr Loudon's survival if action had been taken at any of these stages. Particular actions, omissions or failures may be the subject of comment or criticism, but that is only relevant for purposes of section 6(1)(c) if death might have been avoided.

The possibility of Mr Loudon surviving

7.16 There was evidence that was relevant to this issue from several of the medical witnesses. Dr Shearer's position (on her balance of probabilities approach to the cause of death) was that the depressant effect of drugs allowed bronchopneumonia to develop and put Mr Loudon into a coma, but she could not say how long Mr Loudon had been unwell if he had been in a drug-induced coma. It could have been an hour or a few hours. If he was in such a coma it was not possible for her to assess Mr Loudon's chances of survival. If Dr Cary's opinion was correct that Mr Loudon had bronchopneumonia for several hours, Dr Shearer's position was that if that had been diagnosed it could have been treated by routine treatment by antibiotics, which is very effective.

7.17 Dr Cary in his evidence was unable to state when exactly Mr Loudon's condition of bronchopneumonia developed. He said that bronchopneumonia takes many hours to develop – not less than 4 hours. Mr Loudon could have had it when he arrived at London Road Police Office, but he could not be sure. It was possible it developed during the time Mr Loudon was at the police station. It may not have been present when Mr Loudon was seen by Dr McCall. The condition was treatable and there was a reasonable prospect of survival, although not 100% for someone like Mr Loudon with his health problems. The earlier it was treated the better the prospects of survival. The likelihood of survival would have been

better if Mr Loudon had been treated at hospital at or soon after 8pm. Dr Cary told the PF that “survivability” was greater than 50% if Mr Loudon had been taken to hospital directly or within half an hour or an hour. I took this to mean directly from being arrested or within the stated time period after that. He subsequently added that if Mr Loudon had been taken directly to hospital he would have been in a better place had his deterioration occurred later while he was there, and had he been taken to A & E following deterioration in his condition while in custody he would have been treated more quickly there. Dr Cary’s evidence was also that a person’s chances of survival after septic shock are very low; death can be very quick – less than an hour. There is a better chance of survival where there is sepsis if assistance is given before cardiac arrest, but there was an element of speculation about that, he said.

7.18 As noted above, the Accident and Emergency Consultant who dealt with Mr Loudon on his admission to Glasgow Royal Infirmary was Dr Richard Stevenson. Dr Stevenson had also had several years’ experience of working as a police surgeon. Dr Stevenson expressed the opinion that Mr Loudon was likely to have been suffering from hypoglycaemia for several hours. He was asked by the PF if Mr Loudon could have been saved and stated that he could have had a chance of survival if his glucose level had been corrected, given that he was alive and talking at the charge bar. In stating the opinion that if Mr Loudon had been checked for hypoglycaemia by the police surgeon, as he should have been, Dr Stevenson said that Mr Loudon could have been given a “quick fix” of something to eat and a cup of tea with sugar and then referred to hospital.

7.19 In response to questions in cross examination by Miss Connor, Dr Stevenson confirmed that if Mr Loudon had been brought to him at the hospital from Mr Loudon’s father’s house he would have had a good chance of survival. If he had been brought to the hospital at the time of the examination by the police surgeon he would have had a good chance of survival. Dr Stevenson agreed with the proposition put to him by Mr Stewart for Dr McCall that he could not say with any certainty that if Mr Loudon had been referred to hospital at the time of Dr McCall’s examination he would have survived. Dr Stevenson’s opinion was sought on the question of whether Mr Loudon *might* have survived if he had

been referred to the hospital at the time of the medical examination by Dr McCall and also his opinion on whether Mr Loudon *might* have survived if he had been referred to the hospital at midnight. In response to both those questions Dr Stevenson replied “Yes”. He agreed with Miss Stannage’s suggestion that the longer the time Mr Loudon was not taken to hospital the less chance there was of survival.

7.20 Dr Smith’s evidence was that the petechial haemorrhages in the brain were “recent”, but by that he meant within 12 hours and he could not be more specific. They could have occurred as recently as half an hour before death or as long ago as 12/13 hours. He could not age them. He later said that the petechial haemorrhages and brain swelling was a terminal condition, happening close to death and while bronchopneumonia may have been present for some time the petechial haemorrhages were at the end of the process. It was impossible to say if Mr Loudon was “saveable”, but with overwhelming sepsis recovery is unlikely.

7.21 There was evidence from medical witnesses that the serious medical conditions from which Mr Loudon was subsequently found to be suffering may have caused him to present as being intoxicated, but also that his appearance may have indicated he was unwell. From reviewing the CCTV recording Dr Cary commented that on Mr Loudon’s arrival in custody he looked intoxicated and/or ill, but he was unable to say which. Dr Stevenson’s opinion on viewing the CCTV recording was that Mr Loudon appeared to be suffering from an underlying illness rather than simply being intoxicated.

7.22 The test to be applied in considering, for purposes of section 6(1)(c), whether the death “might have been avoided” is well known and relates to whether there is a “real and lively possibility” that death might have been avoided by a reasonable precaution or precautions. The medical evidence in this case in my view clearly supports a conclusion that there was a real and lively possibility that Mr Loudon’s death may have been avoided if he had been taken to hospital from police custody soon after being arrested or during the earlier part of his detention on the night in question. More difficult, however, is the question of the possibility of survival at a later stage of detention. Account has to be taken, for example, of Dr Stevenson’s agreement with the proposition put to him by Miss Stannage that the longer the time Mr Loudon was not taken to hospital the less chance there was of survival.

7.23 Approaching the question from the direction of working back from the time when Mr Loudon was taken to hospital and examined by Dr Stevenson I do not consider that the evidence which I have outlined is sufficiently clear and persuasive to justify a conclusion that there is a real and lively possibility that Mr Loudon might have survived if he had been sent to hospital at 2am, when a cell check should have been carried out. I am also doubtful about such a conclusion in relation to the 1am prisoner check, taking account of the evidence about the timing of death (set out in the earlier section of this Determination), suggesting that death occurred at some point after the check at midnight and before 3am. In those circumstances it is not necessary or appropriate to consider here the actings of the PCSOs at those times and in particular Mr Anderson's failure to carry out the 2am check. I shall comment further about that in the part of this Determination dealing with section 6(1)(e) of the Act.

7.24 I therefore turn now to consider what I have identified as the first three stages of Mr Loudon's detention by the police:

1. The point at which the original decision to take Mr Loudon directly to hospital was changed and Mr Loudon was taken instead to London Road Police Office.
2. The point when Mr Loudon was examined by the Police Casualty Surgeon, Dr McCall.
3. The point when at the custody officer's midnight check PCSO Richards got no verbal response when he shouted to Mr Loudon from the cell hatch, then entered the cell, found Mr Loudon sitting slumped in the corner of the cell, and with the assistance of PCSO Anderson laid Mr Loudon down on the bed in the cell in the recovery position.

Taking Mr Loudon to London Road Police Office instead of to hospital.

7.25 As noted above, the initial decision to take Mr Loudon to Glasgow Royal Infirmary was changed by the Duty Sergeant, Sergeant McLaughlin, and Mr Loudon was taken instead to London Road Police Office. Of the two arresting officers Constable MacDowell was the officer who appeared from the evidence to be the more concerned about Mr Loudon's condition. In his evidence the officer talked of his concerns about Mr Loudon's health. He also referred to the need for someone who is under the influence of drugs to be assessed by a

medical professional before being detained in police cells. Taking account of Sergeant McLaughlin's evidence (to which I refer below), my clear impression from PC MacDowell's evidence was that PC MacDowell did have a real concern about Mr Loudon's condition after he was arrested and this was the reason why PC MacDowell considered at the time that Mr Loudon should be taken to hospital.

7.26 The evidence of Constable Campbell and Sergeant McLaughlin was mainly to the effect that this was a situation in which the arrested person was under the influence of drugs. However, both in direct and cross examination Sergeant McLaughlin gave evidence to the effect that going on what the officers in direct contact with Mr Loudon said to him at the time the initial decision was made to take Mr Loudon to hospital the judgment of the arresting officers was that Mr Loudon may require medical assistance. There was what I considered to be a minor element of difference between the police witnesses' accounts of the precise circumstances of the decision to change the original decision to take Mr Loudon directly to hospital and take him instead to London Road. However, that did not seem to me to be of any particular significance and the evidence about the reason for the change of plan was consistent and clear. The reason was that the Police Casualty Surgeon, Dr McCall was at London Road Police Office and Mr Loudon could be seen at the police office by Dr McCall, who would be able examine him soon after arrival and make a decision about whether he was fit to be detained.

7.27 The decision was made by the Duty Officer, Sergeant McLaughlin, who also explained in his evidence that he anticipated that had Mr Loudon been taken to the hospital there would have been a delay in him being seen and dealt with there. (There was some confirmation of the accuracy of that assessment in Dr Stevenson's evidence). The fact that taking Mr Loudon to the hospital would have resulted in his two officers being tied up at the hospital was something that was also in Sergeant McLaughlin's mind, but his primary consideration, he said, was Mr Loudon's welfare and the fact that he could be examined more quickly by the Police Casualty Surgeon.

7.28 As I have noted above, Miss Connor for the family submitted that it would have been a reasonable precaution for Police Constables Scott MacDowall and Paul Campbell to have

transported Mr Loudon directly to the nearest hospital as soon as they had concerns over his health and formed the opinion he required medical treatment. Miss Stannage submitted that Sergeant McLaughlin's decision was a reasonable decision for the officer to take in the circumstances. Mr Anderson submitted that it would not have been reasonable for Mr Loudon to have been taken to hospital rather than London Road. Miss Stannage and Mr Anderson drew my attention to Dr Cary's evidence that (from viewing the CCTV recording of Mr Loudon at the police station) he did not think that Mr Loudon needed to be taken immediately to hospital and that it was reasonable that he be examined by a doctor. Dr Cary said that from the video it was appropriate for the police to seek guidance on whether Mr Loudon was fit to be detained, but Mr Loudon did not appear "so bad" that a 999 call was necessary. Dr Stevenson agreed that the police acted appropriately by referring Mr Loudon to the Police Casualty Surgeon.

7.29 I believe the evidence shows that the arresting officers did have a concern about Mr Loudon's health. However, taking account of the evidence to which I have just referred, I am prepared to accept the submissions that Sergeant McLaughlin's decision was a reasonable decision for the officer to take in the circumstances. As an experienced Duty Officer Sergeant McLaughlin had a reasonable expectation that an appropriate medical examination of Mr Loudon could be carried out expeditiously by an experienced Police Casualty Surgeon at the police station.

7.30 Mr Anderson's submission that it would not have been reasonable for Mr Loudon to have been taken to hospital rather than London Road Police Station seems odd in circumstances where the police had originally decided to take Mr Loudon to hospital and the reason for that, as I have interpreted the evidence, was as a precaution in case Mr Loudon needed medical treatment. An argument that it would have been unreasonable for the police to have adhered to their original plan is not persuasive.

7.31 The statement by the PF in her Submissions that "whilst with the benefit of hindsight it would have significantly improved Mr Loudon's chances of survival to have been taken directly to hospital, Police Sergeant McLaughlin's actions at the time were appropriate" is a reasonable assessment of the position, in my view. The PF's assessment of the position

regarding the application of hindsight to the circumstances did not then lead her to make a submission about a reasonable precaution. However, having regard to the medical evidence about Mr Loudon's chance of survival had he been taken directly to the hospital as originally intended, the question is not so much whether Sergeant McLaughlin's decision to divert Mr Loudon to the police station was a reasonable one, but whether it would nonetheless have been a reasonable precaution in the circumstances for Mr Loudon to have been taken directly to the hospital as originally intended. In my view it would have been reasonable for the police to have followed their original plan and taken Mr Loudon to hospital. As there is a real and lively possibility that that course might have resulted in Mr Loudon's survival such action would have been a reasonable precaution whereby the death might have been avoided. It is necessary, however, to make clear that I have reached that conclusion with the benefit of hindsight on the basis of the evidence about Mr Loudon's prospect of survival. As I have said, I accept that the decision at the time to change the original plan and take Mr Loudon to the police office was reasonable and my finding is not intended to be a criticism of that decision.

The examination by the Police Casualty Surgeon

7.32 I turn now to the stage of the examination of Mr Loudon by Dr Andrew McCall at London Road Police Office. Dr McCall is a very experienced Police Casualty Surgeon, who has been engaged in such work since 1993. He has given evidence as a witness in other inquiries into the circumstances of a death in custody. Dr McCall's evidence was that he had no clear recollection of the examination of Mr Loudon. On more than one occasion Dr McCall said that he did not really remember this examination. He said that this case had not stuck in his mind. He required to rely largely on his report, which was Production 7 ("Police Surgeon's Examination Form"), although he was also referred in cross-examination to a statement which he gave to the police on the afternoon of 2 November 2013. Dr McCall agreed that it appeared from that statement that he had seen six prisoners at London Road Police Office that night and he was then asked to hang on to examine Mr Loudon who was being brought into the office and needed to see a doctor.

7.33 In the police surgeon examination form that he had completed, Dr McCall had recorded in the section of the form for the person's address: "67 Slurred". In his evidence Dr McCall maintained that although the address information was incomplete Mr Loudon had been able to provide him with the other information that he had noted. At one point he said – referring, as I understood to information from Mr Loudon: "In this case there was reasonable communication". At another he said that he thought that Mr Loudon's "indifference in engaging" was a factor in making the examination one that he described as "lacking". There appeared to be a lack of consistency between these comments and they both seemed inconsistent with Dr McCall's evidence about his limited recollection of the examination.

7.34 The report completed by Dr McCall recorded that Mr Loudon was "intoxicated" and had "suicidal thoughts of self-harm". It further noted: "on cocaine, heroin, alcohol and valium". Dr McCall stated that he would not have written this unless he had got that information from Mr Loudon, although he also said he thought he heard Mr Loudon give details to the Duty Officer (when Mr Loudon was at the charge bar). I did not interpret that record as necessarily meaning that Mr Loudon had consumed all those substances that day. It was also capable of being construed as indicating that these were substances that Mr Loudon reported he was in the habit of consuming or to which he was addicted. Dr McCall accepted that he told the police in his statement that Mr Loudon had been "a bit vague as to whether he had taken anything that day" and had given a "slurred answer" when asked when he had last taken any of the drugs mentioned. Mr Loudon's heart and lung examination were normal and he had a regular pulse of 76bpm. Dr McCall decided, recorded and advised the police that Mr Loudon was fit to be detained and he confirmed that it was appropriate that Mr Loudon should be placed in an observation cell.

7.35 Dr McCall's evidence was that Mr Loudon walked into the examination room and was able to stand up and walk out of the room. That evidence was based on Dr McCall's viewing of the CCTV video, as he did not remember. Dr McCall was asked by the PF if he was able to remember if Mr Loudon had been slipping in and out of consciousness. His reply was "No. If he had been I would have sent him straight to hospital." Also in response

to questioning by the PF Dr McCall said that when he saw Mr Loudon there were no signs of pneumonia and he remained of the opinion that Mr Loudon was fit to be detained when he examined him. Dr McCall considered that Mr Loudon was intoxicated, but not ill.

7.36 The duration of the examination was extremely brief. Mr Stewart submitted that from the evidence of the CCTV recording (which had timings) and the evidence of those who were asked, Mr Loudon would have been in Dr McCall's room for approximately 1 minute and 50 seconds. I have recorded that the time of 1 minute 57 seconds was mentioned in the questioning of Dr McCall, but that time may have covered the period including walking from and back to the Charge Bar. During the examination Dr McCall did not check Mr Loudon's blood pressure, he did not check Mr Loudon's pupils nor did he check his blood sugar or his temperature or assess him in terms of the Glasgow Coma Scale. He admitted that he did not have with him at the time what is quite basic equipment that would have enabled him to carry out a standard test that the evidence of Dr Stevenson suggested may have helped him to determine if Mr Loudon was just intoxicated or if he was unwell – namely a test for blood sugar. Dr McCall did not record an injury to one of Mr Loudon's fingers which was noted in the post mortem report.

7.37 During a passage of cross examination by Miss Connor in which Dr McCall was asked questions about his evidence about Mr Loudon's suggested indifference, vagueness and slurring Dr McCall made some comments about drug addicts, in which he suggested that vagueness is "at the top of a drug addict's agenda", that it is common for drug addicts "not to tell you ", that "you could be getting a pack of lies" and that a drug addict's agenda is to "get out and get more drugs ". These comments were made in the context of Dr McCall's examination of Mr Loudon, although the doctor accepted that he did not know anything about Mr Loudon and that in making these comments he was generalising, although based on his own experience.

7.38 Also in response to cross examination by Miss Connor, Dr McCall denied that he was in a hurry to get home that night or that he was getting "sloppy". However, as I have noted, Dr McCall in his evidence recognized that the examination was "lacking". At other points in his evidence he said that it was "not a very good examination", that he accepted that there

were “failings” in his medical examination, that it was “overly brief” and that he was “embarrassed” about it.

7.39 As I have noted, both Dr Cary and Dr Stevenson had previously had experience of serving as police surgeons – in the case of Dr Stevenson in Glasgow. Dr Cary’s evidence about Mr Loudon’s presentation in the CCTV video was that Mr Loudon looked intoxicated and/or ill and he needed to be examined in order to say what his condition was. Asked to comment on the report of Dr McCall’s examination of Mr Loudon (Production 7) Dr Cary said that he would expect a thorough examination by the police surgeon. However, he noted that there was no reference to a blood glucose test (which I understood to be the same as a “blood sugar” test), a Glasgow Coma Scale test or examination of the pupils having been carried out. He would be surprised, he said, if a standard assessment by a police surgeon could be carried out in less than 15 minutes. If it took less than that it would involve “cutting corners”.

7.40 Dr Stevenson’s evidence included a description of how a falling blood sugar level would result in a presentation similar to intoxication, including irritation, confusion, aggression and eventually unconsciousness. Asked by the PF if he would have expected the police surgeon to check blood glucose, Dr Stevenson stated that he had seen the video and he would have expected Mr Loudon’s blood sugar to have been checked. He would expect a final year medical student to know and he personally reinforces to junior medical staff the message that where someone looks intoxicated you must check to exclude low blood sugar. At a later point he said “you have to exclude low blood sugar mimicking drug intoxication.” From Mr Loudon’s appearance in the video Dr Stevenson also said he would have looked for infection and even if he had not found it he would have given standard antibiotics.

7.41 On the question of the duration of a medical examination of someone in Mr Loudon’s position, Dr Stevenson thought it would take up to 10 minutes, but it was very hard to say because if he had been carrying out the examination of Mr Loudon he would probably have said to send him to hospital before that. A proper assessment could not be carried out in 90 seconds unless that resulted in sending the person to hospital. He did not think that in an

examination of less than 2 minutes it would be possible to carry out a basic assessment. In Mr Loudon's case Dr Stevenson would have carried out a Glasgow Coma Scale test.

7.42 Asked to comment on whether Dr McCall's examination of Mr Loudon was adequate Dr Stevenson said he did not think that it was adequate and the record of the examination did not demonstrate the condition of Mr Loudon shown in the CCTV recording that he had viewed. He said that had he been the police surgeon and seen Mr Loudon in the condition which the CCTV showed at the charge bar and the holding cell he would have seen Mr Loudon but sent him to hospital. When it was put to him by Mr Stewart that Dr McCall "had the benefit of seeing and speaking to Mr Loudon which he did not", Dr Stevenson agreed.

7.43 I have referred above to the submissions for the Crown and the family inviting me to make a finding about a reasonable precaution or precautions in respect of Dr McCall's examination of Mr Loudon. I do not propose to repeat their terms here. I have also noted Mr Stewart's relevant submissions in the same section above. I have considered these and the more detailed arguments advanced in Mr Stewart's Submissions on behalf of Dr McCall.

7.44 I did not find Dr McCall to be an impressive witness and some of his evidence was concerning. He claimed on several occasions not to remember his examination of Mr Loudon, yet at other points his evidence about particular details seemed to suggest the opposite. These included comments about Mr Loudon's indifference to engaging. He also made certain comments (which I have noted above) about drug addicts in response to questioning in that connection. The nature of these comments in my view raised a possible question about Dr McCall's professional approach to the examination of prisoners such as Ian Loudon. In the context of the important issue of whether Mr Loudon was intoxicated or unwell Dr McCall's evidence that he did not have equipment that would have enabled him to carry out a simple standard blood sugar test that may have assisted with such a determination was also surprising. Dr McCall's own admissions about the inadequacy of his examination of Mr Loudon at least demonstrated commendable honesty on his part on reviewing the position. Such statements by a very experienced police surgeon in respect of a medical examination of a prisoner who subsequently died while in police custody after the doctor had declared him to be fit to be detained are, however, somewhat concerning.

7.45 I have dealt above with the question of a real and lively possibility that a precaution may have avoided Mr Loudon's death. I would only repeat here my view that the medical evidence does support a conclusion that Mr Loudon might have survived if he had been sent to hospital soon after arrest or during the earlier part of his detention. I accept Mr Stewart's comment that "it cannot be said with certainty that an admission might have avoided the death." However, certainty is not the test. I only require to be satisfied on a balance of probabilities that there was a real and lively possibility that the precaution of sending Mr Loudon to hospital at that time might have avoided his death.

7.46 As for Mr Stewart's submission about Sheriff Braid's opinion in the Marianne Bellfield FAI, I am familiar with that opinion having considered it in another quite recent FAI (see my Determination in the FAI into the deaths of Mhairi Convey and Laura Stewart [November 2014] at page 78). Having considered it in the context of the present case I do not find Sheriff Braid's opinion to be helpful in this Inquiry. It is a surprising proposition – and not one that I accept – that Sheriff Braid's opinion may be interpreted to suggest that it is not appropriate for a sheriff at a fatal accident inquiry into a death in police custody to consider and make findings about the adequacy of a medical examination at a police station which resulted in the medical judgment to declare a prisoner fit to be detained and not to refer the prisoner to hospital for further examination or treatment.

7.47 The arguments advanced by Mr Stewart relating to Dr McCall having had the "benefit" (as Mr Stewart put it to Dr Stevenson) of seeing and speaking to Mr Loudon are not persuasive in circumstances where the period of time of Dr McCall seeing and speaking to Mr Loudon was less than two minutes and where Dr McCall admitted that the examination was too brief and there were failings in it. Mr Stewart also submitted that it does not follow from Dr McCall's "entirely appropriate" concession that his examination of Mr Loudon was "too short" that "a more detailed consultation would have led Dr McCall to a different conclusion regarding Mr Loudon's fitness for detention". There was, he suggested, "no reliable evidence before the court to predict what any further examination might have shown". The absence of clear evidence about Mr Loudon's actual condition at the time was substantially attributable to the inadequacy – which was admitted and established on the

evidence – of the examination carried out by Dr McCall before declaring Mr Loudon fit to be detained.

7.48 On my view of the evidence it is reasonable to conclude that Mr Loudon may have been unwell, and not just intoxicated, at the time of Dr McCall's examination, and that an appropriate and adequate examination may have revealed that. Had Dr McCall discovered that Mr Loudon was unwell it is clear from his evidence that he would have directed the police to take him to hospital. Whether it is possible to conclude, as Miss Connor invited me to do, that Mr Loudon "was seriously unwell at the time he was detained in custody" may be more problematic. The evidence from Dr Cary and Dr Stevenson, to which I have referred above, supports a conclusion that Mr Loudon may have been unwell at the relevant time, Dr Stevenson's position being more definite in that regard. I am not sure that it supports a conclusion as a matter of fact that Mr Loudon definitely was "seriously unwell". Nonetheless, a conclusion that Mr Loudon may have been unwell when he was examined by Dr McCall is sufficient, in my view, to justify a finding that an appropriate and adequate examination, which would have allowed a fully-informed judgment by Dr McCall about Mr Loudon's condition, would have been a reasonable precaution that may have avoided Mr Loudon's death.

7.49 There may, in fact, be a doubt about whether such an examination on the occasion in question could have been sufficiently comprehensive to allow such a fully-informed judgment. Account needs to be taken of Dr McCall's evidence that he did not have equipment that would have enabled him to carry out a standard test (for blood sugar) that, on the evidence I heard and accepted, may have enabled him to determine if Mr Loudon was unwell. In those circumstances a referral to hospital may have been necessary in any case to allow the full range of tests that may have been relevant to be carried out. In the circumstances a finding not only in the terms proposed by the PF, but also reflecting part of Miss Connor's submission would be appropriate.

The prisoner cell visit at midnight

7.50 I shall now consider the stage of Mr Loudon's detention when at the custody officer's midnight check PCSO Richards got no verbal response when he shouted to Mr Loudon from

the cell hatch, then entered the cell, found Mr Loudon sitting slumped in the corner of the cell, and with the assistance of PCSO Anderson laid Mr Loudon down on the bed in the cell in the recovery position.

7.51 The relevant evidence about this stage came primarily from the PCSOs Richards and Anderson and the Duty Officer, Sergeant Allan. Both PCSO Richards and, in particular, PCSO Anderson are experienced custody officers. They are both very familiar with dealing with intoxicated prisoners, who (I heard) generally make up a large proportion of the persons held in custody on weekend nights at London Road Police Office. Their evidence was that Mr Loudon had all the appearance of being an intoxicated prisoner. It was common practice for them to place intoxicated prisoners in the recovery position. Mr Richards said he had done it “a thousand times” and he would continue to do it.

7.52 When he entered Mr Loudon’s cell and placed him in the recovery position, PCSO Richards described Mr Loudon as being in a “deep, heavy sleep”. In response to being asked by the PF if Mr Loudon spoke to him Mr Richards replied: “He made a noise” and he repeated that reply when questioned by Miss Connor and Ms Merchant. When referred by Miss Connor to his police statement in which he had said that Mr Loudon was “mumbling” as they moved him, he agreed with that. Mr Richards was referred by Miss Connor to the section of the Police Scotland “Standing Operating Procedures” for “Care and Welfare of Persons in Police Custody” (Production 14) that deals with visits to cells and in particular the statement in bold print at paragraph 13.3.2: **“At each visit, all custodies are to be roused and spoken to and are to give a distinct verbal response”**. Mr Richards agreed with Miss Connor’s suggestion that there was no distinct verbal response when Mr Loudon was put in the recovery position. PCSO Anderson did not recollect any verbal responses from Mr Loudon. He described Mr Loudon as “muttering and groaning” when he was moved. Both officers stated in their evidence that Mr Loudon’s eyes were open and that he opened his eyes when he was moved. When reminded by Miss Connor of their police statements they both accepted that they had not said that to the police. PCSO Anderson’s position was that as far as he recalled Mr Loudon opened his eyes. When Miss Connor suggested to Mr Richards that if Mr Loudon had opened his eyes he would have told the police, Mr Richards

said “fair enough”. It was the position of both officers that they did not have any concerns about Mr Loudon.

7.53 It was accepted by Mr Richards that he made no record in the custody record about the placing of Mr Loudon in the recovery position, although that should have been noted. There was a conflict of evidence between Mr Richards and Sergeant Hall about whether Mr Richards told Sergeant Hall about this. At different points Mr Richards said that he was “sure” that he would have told Sergeant Hall, that he was “99 per cent sure” he would have told him, that he “more than likely” would have done and that he doubted whether he was mistaken. The last comment was in reply to a question about the absence of any such reference in his police statement, which Mr Richards accepted. The penultimate comment was in response to the suggestion that he may not have mentioned it, given all the circumstances including Mr Richard’s evidence about the frequency of placing prisoners in the recovery position.

7.54 Sergeant Hall was clear in his evidence that he was not told about the custody officers’ actions in relation to Mr Loudon at midnight, and in particular about Mr Loudon being placed in the recovery position. He would have expected to be told that. This was also something that should have been recorded in the custody record. Sergeant Hall stated that if he had been told he would have gone to Mr Loudon’s cell to check himself. He would have followed his normal practice of getting an ambulance if a prisoner is not responding, by which he meant giving a positive, affirmative answer and not just mumbling, groaning or opening his eyes.

7.55 Only Miss Connor for the family invited me to make a positive finding in connection with this episode about a reasonable precaution that may have avoided Mr Loudon’s death. The submissions that I have noted above (in paragraph 7.6) include the following submission as a reasonable precaution which if taken by the custody staff would have avoided the death of Ian Loudon: “(iii) Summon urgent medical help when Ian Loudon could not be roused at the check conducted at 2300 hours when staff placed him in the recovery position or transport him to a hospital for assessment.” This clearly relates to the episode which I found proved on the evidence to have occurred at midnight, not 2300 hours.

7.56 The PF did not propose a determination under section 6(1)(c), but in her discussion of this topic in the section of her Submissions relating to section 6(1)(e) of the Act she concluded that PCSO Richards and PCSO Anderson failed to inform Police Sergeant Hall or update the Prisoner Processor System record that they had placed Mr Loudon in the recovery position. As Sergeant Hall's evidence was that had he been informed he would have checked Mr Loudon personally it was the Crown's submission that had Sergeant Hall been informed about that Mr Loudon "may have been taken to hospital earlier." The PF also submitted that what the PCSOs described as "groaning and mumbling" by Mr Loudon could not be considered a "positive verbal response" as per the Standard Operating Procedures guidelines. Ms Merchant for PCSO Anderson made no specific submission about a section 6(1)(c) finding about this episode but invited me to accept the evidence of her client and PCSO Richards about these matters. Mr Anderson for Sergeant Hall offered a supplementary submission in response to Miss Connor's submission set out above. He invited me to prefer Sergeant Hall's evidence that he was not told that Mr Loudon had been moved into the recovery position and that if he had been told he would have gone to see Mr Loudon.

7.57 Miss Stannage's submission about this matter was:

"After this visit Sergeant Hall should have been informed that Mr Loudon had been moved into the recovery position and the Prisoner Processing System updated to show that Mr Loudon had been asleep when Mr Richards and Mr Anderson entered his cell. The latter was certainly not done. It is not clear from the evidence if Mr Richards did tell Sergeant Hall that Mr Loudon had been moved into the recovery position. If he did, however, Sergeant Hall, for whatever reason, did not retain that information. It is clear from his evidence that if he had been given that information that he would have visited Mr Loudon himself and assessed his rousability. Sergeant Hall told the Court that in these circumstances that he would have tried to get a positive response from Mr Loudon and if that had not occurred he would have sent him to hospital. We do not know, however, if at just after midnight on 2 November 2013, if Mr Loudon would have been able to provide such a positive response. In his evidence Dr. Stevenson told the court that he considered that Mr. Loudon's death might have been avoided if he had been taken to hospital at this time. However this evidence was given on the basis that Mr. Loudon died of hypoglycemia and did not take into account the evidence of Dr. Smith. Dr. Smith said that if Mr. Loudon was suffering from swelling of the brain and he could not provide the court with an estimate of his chances of survival at any given point accordingly there is not sufficient evidence to determine that this failure in communication affected the outcome in this case. In my submission it is not practical

that all exchanges of information between custody staff is in written form rather than verbal. Without evidence about how and where these communications could be recorded and how it could be ensured that the right person is reading same I would submit that your Lordship is not in a position to make any finding in this regard."

7.58 In relation to the actings of the PCSOs Miss Stannage acknowledged in her submissions: "Unfortunately, however, a distinct verbal response was not always obtained from Mr. Loudon whilst he was in police custody between 1 and 2 November 2013."

7.59 I am satisfied from the evidence about the midnight cell visit that Mr Loudon did not give a distinct, verbal response to the custody officers Richards and Anderson. It is not in dispute that PCSO Richards did not record information about Mr Loudon being placed in the recovery position in the custody record, as should have been done. I also find that Mr Richards did not report this to Sergeant Hall. I prefer the witness Hall's evidence in that regard. I did not find Mr Richards to be a reliable witness in relation to all aspects of the conduct of his duties on the night in question. I have outlined Mr Richards' variety of answers to questions about whether he told Sergeant Hall. I found it surprising that Mr Richards did not mention in his police statement that Mr Loudon opened his eyes. That raised a doubt about whether that is what he actually observed. (Likewise with PCSO Anderson.)

7.60 The fact that Mr Loudon had been placed in the recovery position required to be reported to Sergeant Hall. On my understanding of the evidence, so also did the failure by PCSOs Richards and Anderson to obtain a distinct, verbal response from Mr Loudon. Both the PCSOs accepted that the relevant part of the police Standard Operating Procedures, to which Miss Connor drew their attention, governed their role. I have mentioned above that Mr Richards was referred by Miss Connor to paragraph 13.3.2, which states: "**At each visit, all custodies are to be roused and spoken to and are to give a distinct verbal response**". Miss Connor also reminded PCSO Anderson of the direction in the section of the procedures document dealing with cell visits (13.6) that "all verbal interactions with the custody during the course of the visit should be also accurately noted" and PCSO Anderson agreed that this was not done. Both the PCSOs claimed to have some familiarity with the guidance. However, the extent of that familiarity was unclear from their evidence.

7.61 I am satisfied that Police Sergeant Hall was familiar with relevant parts of the procedures document, including the procedure to be followed to check “rousability” when it was necessary to do so. I have no doubt that, having regard to his duties relating to the supervision of custody and the care of prisoners which he clearly recognised, he would have attended at Mr Loudon’s cell to check Mr Loudon had he been told about Mr Loudon being placed in the recovery position in the circumstances described in evidence by the witnesses Richards and Anderson. I am satisfied that if PS Hall had carried out such a check and found that Mr Loudon failed to meet any of the criteria set out in the “Observation Checklist” in section 13.4 of the procedures (with which he was familiar) he would have complied with the direction to call medical assistance – or as Sergeant Hall stated himself, he would have sent Mr Loudon to hospital. On the evidence I think it likely that Mr Loudon would have failed to meet one or more of the criteria and he would therefore have been sent to hospital.

7.62 On my view of the evidence, taking account in particular of the evidence of Dr Stevenson, I believe that there was a real and lively possibility that Mr Loudon’s death might have been avoided if that had happened. I refer to my discussion above about Mr Loudon’s prospects of surviving (paragraphs 7.16.-7.23). I note but do not accept the argument advanced by Miss Stannage in her submission, which is set out above. What is relevant is the existence and treatability of hypoglycaemia, not whether it was the cause of death. Also relevant is the evidence about the ability to treat infection and regard should be had to Dr Stevenson’s in evidence in that connection too.

Other matters

7.63 For completeness I should mention that I have noted and considered the other elements of Miss Connor’s detailed submissions about findings that she invited me to make, as well as submissions from those representing other parties directly or indirectly inviting me to refrain from such findings. Miss Connor was critical of other alleged failures, particularly on the part of Sergeant McLaughlin who was the Duty Custody Officer when Mr Loudon was initially brought to London Road Police Office. Those representing the

police and the custody officers relied heavily on the medical evidence that the serious medical condition from which Mr Loudon was found to have been suffering could have caused him to present as intoxicated in submitting that the officers concerned did not have the expertise and could not be expected to tell the difference. Their submissions emphasised the reliance placed by the officers, and in particular the Duty Sergeants, on the fact that Mr Loudon had been medically examined by an experienced Police Casualty Surgeon and declared to be fit to be detained.

7.64 In relation to Sergeant McLaughlin's actions and decisions, I think firstly that Miss Stannage was right in her comprehensive Submission to cover the question of whether the police were justified in detaining Mr Loudon, as that was a question that arose in the Inquiry, albeit that it was not a matter of dispute. I accept that there was legal justification for the police to detain Mr Loudon. In relation to Miss Connor's criticisms and submissions, Miss Stannage submitted that Sergeant McLaughlin "was entitled to rely upon the advice of a very experienced Casualty Surgeon like Dr McCall" and to expect that Dr McCall would have made the relevant checks on Mr Loudon's health and appropriate recommendations about his care. Both Miss Stannage and Mr Anderson submitted that it was reasonable for Sergeant McLaughlin to accept and act on the outcome of Dr McCall's examination of Mr Loudon. I accept those submissions.

7.65 As regards the frequency of visits to Mr Loudon's cell there was, in my view, no clear evidence that would justify a conclusion that more frequent visits would have been appropriate or necessary in the circumstances or, in particular, that they would have constituted a reasonable precaution that might have avoided Mr Loudon's death. I reached the same conclusion about the criticism and related submission about the handover arrangements. To the limited extent that I considered there was substance in the criticism I did not consider that this was a matter of material relevance to the issue of reasonable precautions. I am not satisfied that a determination going beyond the findings that I have mentioned above and which are set out below would be justified on my view of the evidence.

Determination

7.66 My determination under section 6(1)(c) accordingly is:

The reasonable precautions whereby the death might have been avoided were:

1. For the police to have taken Ian Loudon to hospital immediately after he had been arrested at around 8pm on 1 November 2013, as they initially set out to do.
2. For the Police Casualty Surgeon who examined Ian Loudon at London Road Police Office at 8.45pm on 1 November 2013 to have carried out an adequate and appropriate examination of Mr Loudon and to have sent him to hospital.
3. For the Police Custody and Security Officers who placed Ian Loudon in the recovery position in his cell just before midnight on 1 November 2013 to have reported the condition in which they found Mr Loudon and the action they had taken to the Duty Custody Officer and for that officer personally to have checked Mr Loudon's condition and sent him to hospital.

Part 8. Section 6(1)(d) of the Act: Any defects in any system of working which contributed to the death.

8.1 The Duty Sergeant's "Care Plan" procedure, the examination of an arrested person by a Police Casualty Surgeon to assess the person's fitness to be detained, the regular checking of a prisoner who has been detained in custody in a police cell, and the constant observation of a prisoner in a police cell by CCTV are elements of a system of working intended to protect the wellbeing of a citizen who has been deprived of his liberty and consequently his ability to take action himself to look after his own wellbeing. The Police Scotland "Standing Operating Procedures" for "Care and Welfare of Persons in Police Custody" sets out the procedures to be followed and are part of the system. These measures and procedures all have as their purpose the protection of the wellbeing of a prisoner in police custody, including ultimately the prevention of the death of such a prisoner.

Submissions

8.2 Only Miss Connor on behalf of the family of Ian Loudon had submissions to make

which I interpreted as inviting me to make a determination under this head. The PF had no submissions and the other parties either made no submissions or submitted that there were no defects in any system. I do not consider it necessary to set out Miss Connor's submissions in full here. It will suffice to note that they refer to the guidance and directions contained in the Police Scotland "Standing Operating Procedures" for "Care and Welfare of Persons in Police Custody" (Production 14), to which I have referred. Miss Connor mentions a number of specific provisions of the operating procedures and makes comments and criticisms about officers' actions in relation to them, her primary submissions being that "the evidence demonstrated a failure by those charged with managing the system to take any steps to see that specified procedures were being implemented" and that "officers had no more than a rudimentary understanding and awareness of the provisions contained in Crown Production 14 and did not apply them in carrying out their duties." In Miss Connor's submission "the provisions of the Procedures have not been implemented by the police authority." Further particular criticisms about the system related to a lack of training and a lack of supervision of staff. Miss Connor did not formulate any specific proposed finding that she invited me to consider and adopt for a determination under this head.

8.3 Miss Stannage devoted attention in her submissions for the Chief Constable to addressing system points in support of her contention that "there is no evidence to support a finding that the system of working operating at London Road Police Office in November 2013 contributed to Mr Loudon's death". In relation to the Police Scotland "Standing Operating Procedures" for "Care and Welfare of Persons in Police Custody" Miss Stannage comments that this is "a lengthy document which does endeavour to cover all common eventualities in police custody suites." She continues: "It cannot, of course, cover every eventuality. Nor can officers dealing with prisoners be expected to be aware of and adhere to the letter of such a complex document. A practical approach must be taken to some parts of the procedures." In her submission "there is no evidence that any failure to comply with these procedures contributed to Mr Loudon's death". Miss Stannage's submissions include this comment: "Given the evidence of Mr. Anderson and Mr. Richards, ... it may be appropriate to try to find new ways to ensure that custody staff remain aware of the terms of at least the parts of the procedures relevant to them."

Discussion and determination

8.4 As I mentioned in the first paragraph of this section the measures and procedures that I described in that paragraph (and that are discussed in the submissions for the family and the Chief Constable) all have as their ultimate purpose the prevention of the death of a prisoner in police custody. Those measures and that system failed to achieve that intended purpose in the case of Ian Loudon.

8.5 It is necessary to consider whether there were any defects in the system as such or if any failures were failures to operate appropriately a system that was of itself essentially satisfactory. Even if criticisms of the operation of the procedures or of compliance with the guidance and directions were found to be justified there is a question whether such shortcomings or failures would fall to be covered by a determination under section 6(1)(d). Miss Connor's submission appears in large part to be that failures to act in accordance with the prescribed procedures constituted a defect in the system of working. For a finding to be made under the section it would also be necessary to be satisfied that a defect or defects in the system of working "contributed to the death". That element is not specifically addressed in Miss Connor's submissions.

8.6 The Police Scotland "Standing Operating Procedures" for "Care and Welfare of Persons in Police Custody" constitute a detailed and substantial set of guidance and directions for police staff involved in the custody of prisoners. The statement of procedures was not itself criticised in Miss Connor's submissions and on the evidence I heard it did not seem to me that this document or the procedures set out therein were defective.

8.7 I have considered the evidence and submissions about the system of prisoner processing and prisoner care and various particular elements thereof, such as the shift handover arrangements, the recording of information, the cell checking and observation arrangements, the supervision of custody staff, and the training of custody staff. One matter to which I have given particular attention is the matter of the awareness and understanding of the guidance and directions in the Standard Operating Procedures on the part of the Police Custody and Security Officers, having regard not only to Miss Connor's submission but also Miss Stannage's comment to which I have referred above.

8.8 Miss Stannage's comment: "Given the evidence of Mr. Anderson and Mr. Richards, however, it may be appropriate to try to find new ways to ensure that custody staff remain aware of the terms of at least the parts of the procedures relevant to them" followed her comments on the length and scope of the Standard Operating Procedures and a statement that the document "is available to all officers of Police Scotland on the force intranet and emails advise of updates to a procedure which governs the officer's area of business". The comment about the evidence of the two PCSOs appears to suggest some reservations about the adequacy of those officers' awareness of the procedures and also of the arrangements in the system for ensuring such awareness. My view of the officers' evidence is that it was suggestive of some awareness and understanding of the relevant provisions of the Standard Operating Procedures on the part of the officers, but perhaps not a clear and full awareness and understanding. I accept Miss Connor's criticism to that extent at least. I am not persuaded, however, that there was a related defect in the system that positively contributed to Mr Loudon's death.

8.9 Having considered the foregoing particular matter and the evidence and submissions about the other various elements of the system of prisoner processing and prisoner care I am not satisfied, in relation to these matters, that the evidence demonstrates the existence of a defect or defects in the system that specifically contributed to Mr Loudon's death. I do not consider that it is necessary or appropriate to go beyond my findings in relation to possible precautions whereby the death might have been avoided (in terms of section 6(1)(c)) and to make any specific finding under section 6(1)(d) of the Act.

8.10 Therefore, in relation to Section 6(1)(d) of the Act, I have no finding to make concerning any defects in any system of working which contributed to the death.

Part 9. Section 6(1)(e): Other facts which are relevant to the circumstances of the death.

9.1 There are some outstanding matters that I believe may appropriately be dealt with under this heading. Most of the parties' submissions did not seek any determination or offer any comment under this section. The Crown submission includes discussion of a number of

matters which I have in fact covered in earlier sections of my Determination. Miss Connor raised one particular matter and also asked me to consider her section 6(1)(d) submissions here if I did not consider them under that section. I have given consideration to Miss Connor's section 6(1)(d) submissions, so far as I consider relevant, in the previous section of this Determination.

9.2 However, I turn now to the particular matter which related to the Police Casualty Surgeon arrangements. Noting the vital role of Police Casualty Surgeons in safeguarding the welfare of prisoners, Miss Connor suggested that the reliance placed by the police and custody staff upon their advice may be to the detriment of a prisoner. She observed: "There does not appear to be any system of supervision or check on doctors carrying out this role. There does not appear to be any quality control assessment of the service provided by doctors in the position of Dr McCall, particularly peer supervision or assessment, even on a random basis." She invited me to consider "whether there should be a system whereby the public can be assured that those operating in that role are adequately performing their duties". The evidence that I heard in this connection was limited. There was also evidence that since April 2014 the NHS has assumed responsibility for the provision of medical assistance to prisoners in police custody in the Greater Glasgow Health Board Area. I am unclear whether that change of arrangements has affected the position in relation to any question of the assessment of Police Casualty Surgeons. Some of the witnesses expressed the opinion that the new system involving the NHS has improved the medical arrangements for persons in custody. The evidence about the matter raised by Miss Connor does not, in my view, provide a sufficient basis for any formal finding.

9.3 Turning to the matter of prisoner visits, I indicated above that I would comment further on the 2am prisoner visit in this section of my Determination. The failure of PCSO Anderson to carry out that check was unfortunate. I am satisfied it was an oversight. It was clear from the CCTV recording that PCSO Anderson was at the cell door and on the point of making the check when he was distracted by being called away for some reason that he could not recall. A genuine mistake was made, which PCSO Anderson only discovered when some time later he viewed the CCTV recording. The inaccurate recording in the

custody record by PCSO Anderson's colleague, PCSO Richards, that the check had been carried out and the fact that the record was made not by the officer concerned but by his colleague are unsatisfactory aspects of this episode. As regards the latter, Miss Stannage commented in her Submissions: "This should not have happened. The record should have been made by the person making the visit." Miss Stannage points out that this should no longer occur since a change was made in the system with the introduction of the "prisoner contact record", about which I heard evidence. As that record requires all interactions with prisoners to be recorded in writing on the record form it appears that this may also strengthen the system in relation to whether or not a "distinct verbal response" has been obtained. The new arrangement that has been put in place in the period since November 2013 in relation to the recording of information about visits to prisoners in their cells demonstrates commitment on the part of the police service to strengthening the previous arrangements and the protection of prisoners in that regard.

9.4 I think it is appropriate to return here to the question of the custody officers' awareness of the Standing Operational Procedures that was discussed in paragraph 8.8 above. Miss Stannage's comment about finding "new ways to ensure that custody staff remain aware" of the relevant parts of the procedures may suggest a training point as regards maintaining and reinforcing awareness and understanding. I have considered whether there is any observation or recommendation to be made in that regard. Relevant evidence about current training was fairly limited and it was not clear what the position is about training in relation to the new "prisoner contact record" arrangements. It is possible that the introduction of those arrangements may of itself have improved awareness and understanding. I accept Miss Stannage's observation, but I do not believe that it is necessary or appropriate to make any specific finding in that regard.

9.5 I have mentioned the arrangements for cell observation by CCTV. There was evidence that the system in use should record such observation, so that it should be possible subsequently to view events in the cell, including at an Inquiry such as this. I do not, however, consider that the absence of such recordings was detrimental to the conduct of the Inquiry. Nor do I consider that the evidence suggested any significant weakness in the

system arising from the relatively poor quality of the images – so long as the purpose of observation is clearly understood (as it generally appears to be) to be in connection with self-harm/suicide risk and not to monitor the health of the prisoner. Further there was no evidence to lead me to conclude that the arrangement whereby one officer carries out surveillance of several cells at the same time is not a reasonable arrangement, including having regard to the use of police resources.

9.6 In all the circumstances I have no formal finding to make concerning other facts which are relevant to the circumstances of the death.