

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNFERMLINE

DETERMINATION

of Sheriff John Craig
Cunningham McSherry in Fatal
Accident Inquiry concerning the
death of Angus MacDonald
Malone under the Fatal Accidents
and Sudden Deaths Inquiry
(Scotland) Act 1976

14th October 2009

The Sheriff, having resumed consideration of the cause, Determines:-

1. In terms of section 6(1) (a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act), that Angus McDonald Malone, whose date of birth was 13th April, 1966, latterly residing at 62 Rosewell Drive, Lochgelly, died in Male Observation Cell 14, Dunfermline Police Station, Holyrood Square, Dunfermline between 00.43 and 07.55 hours on 13th August 2007.
2. In terms of section 6(1) (b) of the Act, that the cause of death was the adverse effects of Morphine and Diazepam.

3. In terms of section 6(1)(c) of the Act, considering that Mr Malone brought the drugs with him into custody, either internally or on his person, and that he self administered such drugs, that the reasonable precautions whereby the death might have been avoided are:-
- (a) On 10th August 2007 there ought to have been a thorough strip search carried out on Mr Malone when he was initially taken into custody in Dunfermline Police Station.
 - (b) On 12th August 2007 there ought to have been a thorough strip search carried out on Mr Malone when he further claimed to have taken drugs, to have stored them in his rectum, did produce wrapping and had faeces on his hands.
 - (c) On 12th August 2007, such claims having been made by Mr Malone, there ought to have been a thorough search of Female Cell 4, in which he had been placed.
 - (d) On 12th August 2007, such claims having been made by Mr Malone, the Force Medical Examiner (FME) should have been summoned to attend immediately to examine and question Mr Malone in respect of thereof.
4. In terms of section 6(1) (d) of the Act, the defects in the system of working which contributed to Mr Malone's death were:-
- a. The lack of a consistent approach to the communication of information by Custody staff in the procedure at handovers.
 - b. The lack of full and accurate recording of all visits made to Mr Malone in the cell file and the failure of Custody staff to familiarise themselves fully with the cell file for Mr Malone.

- c. The lack of clear guidelines as to the protocol to be followed when Custody staff thought it necessary to contact an FME to attend upon Mr Malone.
 - d. The lack of adequate training for Custody staff on drugs related matters which would be likely to assist them in the care of custodies who were drug abusers.
 - e. The lack of an adequate number of Custody staff on duty at peak times at weekends.
5. In terms of section 6(1) (e) of the Act, in addition to those facts mentioned above, facts relevant to the circumstances of the death of Mr Malone are :-
- a. That his death was caused by his voluntary consumption of a mixture or ‘cocktail’ of drugs.
 - b. That there have been improvements in custody care since the death of Mr Malone, including the appointment of a Force Custody Inspector, improved training and changes in cell file recording and the procedures at handovers.

The Facts and Circumstances surrounding Mr Malone’s Death:-

1. On Friday 10 August 2007, Mr Malone contacted the Police and complained that he was in danger from others, who were outside his house at 62 Rosewell Drive, Lochgelly. Police Officers attended and found no evidence to verify his complaint. Mr Malone prevented them from entering his house for approximately 40 minutes. Mr Malone would have had time to secrete drugs on or in his person. Mr Malone was arrested and charged with wasting police time. Controlled drugs were found in his house.

2. On arrival at Dunfermline Police Station, Mr Malone was asked all the relevant questions in the risk assessment that was used at that time. Mr Malone denied any involvement or use of drugs when asked. As a result of his known history and that he was noted on the Police computer as a drugs user, he was marked as a special risk. This was the medium category of risk.
3. He was placed in Male Cell 2. He was strip searched and this search lasted for less than a minute. This strip search was conducted by PC Marshall and PC Russell. Neither of these officers had any comprehensive experience of drug abusers. DC McLaren and Superintendent Plastow, who had such experience, were shown the video relating to the strip search and thought the search to be inadequate. DC McLaren detailed what was involved in carrying out a strip search and said that it would take 5 minutes. Superintendent Plastow thought that a strip search could not be properly carried out in less than 3-4 minutes. Both DC McLaren and Superintendent Plastow made the point that, if Mr Malone had fully concealed drugs internally, it would be unlikely that they would have been discovered, even if a proper strip search had been carried out. The internal concealment was likely to have been either by internal ingestion or within the rectum. DC McLaren thought that it was more likely that Mr Malone had swallowed the drugs in a package. If so, they would not have been discovered in a proper strip search. My concern is that, had there been partial concealment of drugs, for example, in Mr Malone's rectum, a proper strip search would have led to their discovery. Furthermore, the strip search having been carried out in what appears to have been great haste, the thoroughness of the search of Mr Malone's clothing was also possibly open to question, although internal concealment was more likely.

4. The custody care procedures which were to be complied with by the Custody staff are laid down in the Fife Constabulary Standard Operating Procedures, (SOPS). This document did not simply provide guidance but provides that its application is mandatory for all police officers and support staff of Fife Constabulary, who may be involved in the procedures it describes. Indeed, it provides that failure to adhere to the procedures may result in disciplinary action. The Custody staff, who gave evidence, exhibited varying degrees of awareness of these SOPS, some treating it as a reference manual to be consulted only when unsure of procedures to be followed. The SOPS document was Crown Production 53.
5. Throughout the weekend of 10th to 13th August 2007 Mr Malone presented as volatile and disruptive. His moods varied greatly and the forbearance of Custody staff as shown in the video evidence was remarkable. The care of custodies necessarily involved Custody staff in considerable stress and the cells were described by Superintendent Plastow as a 'high risk area'.
6. On Saturday 11th August 2007, as a result of his disruptive behaviour, which was disturbing other prisoners within the male cell block, Mr Malone was moved to female cell 4, which was situated furthest from the male cell block. There were extra mattresses stored near this cell which assisted in absorbing sound. It was accepted by witnesses that female cell 4 was particularly cold.
7. At approximately 14.55 hours on Saturday 11th August 2007 Mr Malone disclosed to PC Porter that he had taken 500 "blues" He made a similar disclosure to PCSO Simpson at 15.57 hours on the same date and then again to PS Reid at 18.14 hours. The illness and injury form was completed on cell file

at 18.52 hours and the FME was contacted. At approx 19.24 hours Mr Malone advised that he had secreted tablets up his rectum.

8. At 01.00 hours on the 12th August 2007, Dr Hiremath, the principal FME, attended and examined Mr Malone. She concluded that Mr Malone was not under the influence of any drugs whatsoever. She did ask him specifically about whether he had consumed or concealed drugs and he denied both of these allegations.
9. At 08.39 hours on 12th August 2007 Mr Malone told PCSO Lacey that he had taken 500 “blues” during the night and a further 500 that morning.
10. At 08.56 hours on 12th August 2007 PS Collingswood spoke to Mr Malone about this claim and Mr Malone confirmed it and said that the 500 “blues were just kicking in.” PS Collingswood advised Mr Malone that he would have a doctor attend. PS Collingswood did not believe that Mr Malone had consumed the drugs he claimed to have consumed. As he did not exhibit the symptoms, such as drowsiness, associated with taking diazepam, PS Collingswood did not believe that Mr Malone had taken any drugs whilst in custody.
11. At 09.15 hours on 12th August 2007 Mr Malone again spoke to PS Collingswood and reminded him that he had said the same on 11th August to other Custody staff. He then produced a cellophane wrapping and said that the “blues” were homemade. PS Collingswood placed the piece of wrapping on a paper towel. He, rather surprisingly, did not regard the wrapping as material evidence. More importantly, its production did not cause him to revisit in his own mind whether there might be some substance in Mr Malone’s claim. Yet he made a note of the discovery on the Injury/Illness report. In explanation, he said that the wrapping was consistent with bags used in prisoners’ meals and it

had been clean. PC Law, who was involved in the supply of such meals to prisoners, confirmed that no such wrapping was ever used. She also said that PS Collingswood had said that the wrapping was similar to bags used by dealers. DC McLaren believed that drugs would have been placed in a bag and that other bags would have surrounded it to retain moisture and prevent leakage. The outer bag would always have excrement on it but the inner bags would not. The wrapping shown to PS Collingswood was possibly from an inner bag. No search of Mr Malone's person, clothing or female cell 4 was carried out.

12. At 09.25 hours on 12th August 2007 Mr Malone asked PC Law for water and advised her that he "had ½ ounce of smack (heroin) up his arse". She passed this information to PS Collingswood, who asked her to put an intelligence entry on the data base. The discovery of faeces and the bag were also entered. No entry regarding heroin was made on the cell file. PC Law did hear PS Collingswood mention heroin when on the telephone to someone. Again no search of Mr Malone's person, clothing or female cell 4 was carried out.

13. At 09.49 hours on 12th August 2007, PS Collingswood spoke on the telephone with Dr Anderson, the FME who was on duty that day. He told the Dr Anderson that Mr Malone had claimed the previous evening to have taken 500 diazepam tablets and that he had been examined by Dr Hiremath who found no evidence to substantiate his claim. He said that he asked Dr Anderson to attend to examine Mr Malone and that he gave Mr Malone's name. Dr Anderson, while agreeing that he had had been instructed to attend, denied that he had been told the name of the prisoner concerned. PS Collingswood also said that he had mentioned heroin to Dr Anderson. Dr Anderson denied this.

Dr Anderson said that he would come out to Dunfermline Police Station later that day. He did not specify when he would be coming. He told PS Collingswood to observe Mr Malone every half hour and to note if there was any change in his demeanour. When Dr Anderson attended Dunfermline Police Station later in the evening he did not examine or question Mr Malone. He said he had not been asked to do so. PS Collingswood appeared genuinely surprised to be told that the doctor had not examined Mr Malone and had assumed that he had been examined. He could not explain why there had been no examination. He had left the injury /illness form in a pile of such forms for the attention of the doctor at the front desk and there had been a “D” marker put on Mr Malone’s cell file. This marker apparently is removed when a prisoner is seen by the FME. There was no “D” marker remaining on Mr Malone’s cell file. Those taking over from PS Collingswood were unaware that Mr Malone was due to be examined by Dr Anderson. There was no examination of the illness/ injury reports to identify who was to be seen by the FME. I was not too impressed by the off-hand and defensive attitude Dr Anderson displayed in respect of his duties as FME. I find it hard to believe that, having examined a number of prisoners, he did not ask to examine Mr Malone or seek the identity of the prisoner, who was the subject of the telephone conversation with PS Collingswood earlier that day. He kept no notes of instructions received from custody sergeants and appeared confused as to what exactly was said in the course of the telephone conversation. Neither he nor PS Collingswood thought it a matter of urgency that an FME attend and examine Mr Malone.

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14. At 09.52 hours on 12th August 2007 PS Collingswood advised Mr Malone that the Doctor would come out later. Mr Malone repeated his claim that he had heroin secreted within him and that he would “snort the lot.” Again no search of Mr Malone’s person, clothing or female cell 4 was carried out.
15. At 10.40 hours on 12th August 2007 Mr Malone’s cell and hands were found to be covered in faeces. He asked to wash his hands which he did. Again no search of Mr Malone’s person, clothing or female cell 4 was carried out.
16. At 10.51 hours on 12th August 2007 Mr Malone was removed from female cell 4 and placed in an observation cell, male cell 14. There was evidence that he was moved as female cell 4 was uninhabitable and required to be thoroughly cleaned. There was other evidence that Mr Malone was moved in order to keep a closer eye on him. It is clear that Mr Malone was not put into this observation cell for the purpose of constant observation. He was to be observed every half hour rather than every hour. This was later reverted to one hourly observation as Mr Malone’s demeanour had not changed. No medical advice was sought by Custody staff before this change in the observation intervals was affected.
17. Between 11.18 hours on 12th August 2007 and 00.43 hours on Monday 13th August 2007, CCTV evidence, in Crown Production 38, showed Mr Malone appearing to take substances on 12 occasions while in male cell 14. No member of the Custody staff witnessed this as no one was constantly monitoring or indeed paying any attention to the CCTV screen relating to male cell 14. Mr Malone tended to take the substances soon after he had been visited by Custody staff. He was seen to take the substances from his trousers and take them with water.

18. As there was no evidence of faeces or wrapping, associated with drugs' concealment, coming to hand during the time Mr Malone was in male cell 14, it is probable that he had recovered the drugs from his person in female cell 4 before moving to male cell 14. Had he been strip searched thoroughly before being moved, it is probable that the drugs would have been discovered.
19. Mr Malone was last seen moving at 00.43 hours on Monday 13th August 2007.
20. Mr Malone was found unresponsive in his cell at 07.55 am on the 13 August 2007. Efforts were made to revive him, but to no avail.
21. Ambulance personnel took Mr Malone to Queen Margaret Hospital.

NOTE.

At this enquiry conducted by Mrs Catriona Dalrymple, Procurator Fiscal, Fife Constabulary were represented by Mr Fraser Munro, Solicitor, and Mr Malone's sister, Miss Eve Malone and his family were represented by Mr Edward Christie, Solicitor. A total of 25 witnesses were heard during 18 days with a further day for submissions. A joint minute of agreement concerning evidence, relating to arrest and post mortem reports and analysis, was also lodged in process.

Time and Place of Death.

My finding as to when and where the death took place is based upon the evidence that he last spoke to officers when in the male observation cell 14 of Dunfermline Police Station at 00.43 hours on Monday, 13th August 2007. There were seven subsequent visits made to Mr Malone's cell up to 06.29 hours. He was recorded as sleeping. The cell was entered at 07.55hours, resuscitation was attempted but was unsuccessful. Dr

Saddler indicated that he was unable in the circumstances to give a precise time of death.

The Cause of Death.

The cause of death was stated in the Post Mortem Report prepared by Dr Elizabeth Lim and Dr David Saddler and stated by Dr Saddler in his oral evidence as being the adverse effects of morphine and diazepam. The Forensic Toxicology Report indicated that the results of tests carried out following Mr Malone's death were 5.7 milligrams of diazepam per litre, 4.56 milligrams of nordiazepam per litre and 0.22 milligrams of morphine per litre. Dr Saddler said that the 0.22 reading for morphine was at the lower end of what might be a lethal dose. However, the readings for diazepam and nordiazepam were described as being as high as Dr Saddler had ever seen. There would have been a "cocktail effect" with the combination of the diazepam and the morphine. However, Dr Saddler said that the amount of diazepam consumed by Mr Malone was a fatal dose in itself. Dr Saddler's evidence was that diazepam is rarely lethal but fatalities can arise at a level of 5 milligrams per litre. The result showed a level of 5.7 milligrams and would have been higher when taken.

There was no evidence that Mr Malone obtained the drugs from anywhere other than his own person whilst in custody. He made claims during Saturday, 11th August 2007 that he had consumed a substantial amount of diazepam. He displayed no symptoms during the day and he was physically examined by Dr Hiremath at 01.10 hours on Sunday, 12th August 2007. She noted that there were no signs of overdose. Mr Malone made further claims of substantial diazepam consumption were made in the morning of Sunday, 12th August 2007 but again he showed no symptoms consistent with these claims. The C.C.T.V. evidence showed Mr Malone appearing to take tablets whilst in

male observation cell 14. It is a reasonable inference that he was consuming diazepam and morphine. There was no evidence of any wrapping found within him in the Post Mortem examination. It is, accordingly, not the case that he died as a result of such packaging having burst or leaked whilst concealed internally. As Mr Malone was behaving aggressively up until around midnight and the effect of diazepam is drowsiness according to Dr Saddler, it would appear that he had an extremely high tolerance level. This tolerance level may have contributed to the impression of various custody staff that as Mr Malone was not displaying the usual symptoms, he must have been making false claims of drug taking whilst in the cells.

Reasonable Precautions.

In any examination of what reasonable precautions which might have avoided Mr Malone's death, it is not for me to apportion blame. That is not the purpose of this Inquiry. In this case, it must be understood that Mr Malone, and he alone, chose to consume these drugs. There was no evidence that he deliberately intended to cause his own death. Persons like Mr Malone are called in modern parlance "vulnerable". The custody staff involved in Mr Malone's care ought to have been aware that such persons should not be expected to tell the truth at all times nor should they be expected to behave rationally. The initial complaint that his house was surrounded which caused the police to attend at Mr Malone's home and which complaint appeared to be false may be evidence of this behaviour. Similarly, his claims of drug taking and drug concealment coupled with denials may be so regarded. Such vulnerable persons are quite capable of accidentally overdosing and, regrettably, there is much evidence in Fife and elsewhere to confirm this.

It is possible that had there been through strip searches carried out on Mr Malone on 10th August 2007 when initially brought into custody and on 12th August 2007 when he further claimed to have taken drugs, to have stored them in his rectum, produced wrapping and had faeces on his hands. It is similarly possible that on 12th August 2007 there ought to have been a thorough search of Female Cell 4, in which he had been placed. It is possible that he may have secreted drugs within that cell. Had drugs been found he would not have been able to have consumed them.

Furthermore, on 12th August 2007, such claims having been made by Mr Malone, the Force Medical Examiner (FME) should have been summoned to attend immediately to examine and question Mr Malone in respect of thereof. It is possible that had Dr Anderson attended and questioned Mr Malone that this may have lead to the discovery of the drugs or that Mr Malone might not have chosen to consume them. This possibility is rather remote. However, there may have been abnormal readings which would have prompted some other action such as taking Mr Malone to hospital where he would have been constantly monitored. There was considerable doubt and confusion expressed both by PS Collingswood and Dr Anderson as to their respective responsibilities and duties involved in arranging for the FME to attend. Dr Anderson, in addition, also gave the impression of not being aware of which police station had made the call. Accordingly, he neither noted the identity of the police station, nor that of the Custody Sergeant nor that of the custody concerned. As a result he did not ask to see Mr Malone. He left it for the Custody Sergeant to take the necessary steps to bring the custody to his attention when he chose to visit the police station. This did not display, in my view, a proper professional approach. Dr Anderson did not examine Mr Malone. PS Collingswood did express shock that this had not been done

as he had followed the procedure, applicable at that time, of leaving out the illness/injury form applicable to Mr Malone for the attention of the visiting FME.

Despite having been instructed by Dr Anderson to maintain 30 minute checks on Mr Malone, this frequency reverted to one hourly checks without any reference to the FME. The relevance of this is that had there not been such a change, Mr Malone might not have been allowed to remain undisturbed throughout the night. It is concerning that the frequency of observation intervals was changed without reference to the FME. In my view, there was so little observation of Mr Malone taking place that its frequency might not have been material. In any event, the evidence was that custody staff did not as a rule attempt to rouse prisoners who appeared to be asleep. Possibly, if Mr Malone had been roused every half hour his death might have been avoided but the medical evidence was that once a potentially fatal overdose of, particularly, diazepam has been taken, it would have been extremely difficult to have effected a successful recovery.

Defects in the system of working.

I do not agree with Mr Munro for Fife Constabulary that there were no such defects. This case was not on all fours with that of GD McLellan in which Sheriff McCreadie issued a determination on 6th July 2007. In that case there was human error on the part of one police officer. Here, despite the existence of the SOPS, there were numerous failings by a number of officers to follow the prescribed procedure, a lack of procedure particularly regarding the protocol in instructing attendance of an FME and failings in training. There was a lack of a consistent approach to the communication of information by Custody staff in the procedure at handovers. Sometimes this would be done verbally using a white board at the Charge Bar. At other times, there may

have been reference to the cell file. On other occasions nothing was recorded in the cell file at all, such as the disclosure of possession of heroin. There was no full and accurate recording of all visits made to Mr Malone in the cell file and there was a failure of Custody staff to familiarise themselves fully with the cell file for Mr Malone.

As indicated, there was a lack of clear guidelines as to the protocol to be followed when Custody staff thought it necessary to contact an FME to attend upon Mr Malone. Hence the confusion between PS Collingswood and Dr Anderson resulting in a failure to have Mr Malone examined immediately or when the Doctor chose to call. The various Custody Sergeants involved allowed their own views based on prior experience of him or such informal information passed between them to influence their judgement of what was required in the care of a difficult but vulnerable person. Had they had adequate training on drugs related matters this would have been likely to assist them in reaching a more objective view of what was required to have been done with a drug abuser such as Mr Malone. A number of custody staff opined that the SOPS could not be followed to the letter at peak times during busy weekends as there was a lack of an adequate number of Custody staff on duty. This number was on occasions supplemented by taking into the cell area a police officer from his or her duty in the police station. There was no proper provision for the availability of this extra staff which might not be available if there were more pressing duties elsewhere.

Other Relevant Facts.

I am quite satisfied that Fife Constabulary takes very seriously the care of custodies. I was referred to an earlier Inquiry held by Sheriff Holligan into the death of John McLellan in 2003. Sheriff Holligan recommended the following:

- (i) introduce and maintain regular training of police officers as to the care and management of drug abusers;
- (ii) review procedures for the detention of known suspected drug abusers;
- (iii) review the role and responsibilities of the duty sergeant with a view to enhancing its importance;
- (iv) improve training in relation to the use of Cell file so as to
 - (a) ensure a complete record of the time in custody,
 - (b) ensure training on a regular basis in the use of Cell file,
 - (c) introduce procedures to ensure Cell file is regularly consulted,
 - (d) consider simplifying the use of Cell file,
- (v) review the use of special risk and low risk category;
- (vi) consider the introduction of ‘special measures’ as a new category;
- (vii) ensure that custody procedures are regularly reviewed and checked.”

I heard evidence that Fife Constabulary had, prior to these recommendations, already reviewed custody care and that Sheriff Holligan’s recommendations echoed the Force’s own conclusions. There was an action plan setting out the manner in which Sheriff Holligan’s recommendations were to be implemented. In 2006 there was some centralization by reducing the number of police stations, which held custodies and the introduction of custody teams, each with a sergeant and police custody security officers. There was now a fairly intensive training programme and detailed and comprehensive Standard Operating Procedures.

Superintendent Plastow, who came from Lothian and Border Constabulary to Fife and who was highly knowledgeable in national custody care procedures was of the view that custody care in Fife was better than average. I was told that the situation now

differs from that in August 2007. I was told that lessons had been learned. The main changes were that there is a new Vulnerability Assessment; Sergeants have been reminded of the obligation to review the Cell file at the start of a shift and this is now also an obligation to be discharged by inspectors; shift patterns have been adjusted; additional training has been provided; handover briefings now incorporate a walk round the cells and there is now a Force Custody Manager. In addition, there are now national guidelines and Fife Constabulary's Standard Operating Procedures have been revised to reflect the national position. Superintendent Plastow's evidence was that if the claims made by Mr Malone were to be made now, the reaction would be immediate hospital admission.

Nationally there has been the introduction of a National Custody System, which will bring benefits. I was satisfied that Fife Constabulary was responding to this and in the long term intended to have a centralized, purpose-built custody unit. From my own examination of the cell area at Dunfermline Police Station it is clear that the facilities are far from ideal for both the custody staff and inmates. The cells, 14 for males and 4 for females, were never intended to house so many custodies that at peak times there is doubling or even trebling up in each cell. It would make more sense ideally to have a modern purpose-built centralised unit. It was also mooted by Superintendent Plastow that custody care in future should possibly no longer rest with the police. It is obvious that the demands of custody care have changed considerably as a far greater percentage of custodies today have very serious medical problems associated with abuse of drugs and alcohol. Custody staff were being called upon to take immediate decisions on the health and welfare of custodies that only properly trained medical staff should take. The proposed custody unit would have nursing staff on the premises.

I note that despite obvious restrictions on its budget, Fife Constabulary continues to devote resources to review and improve custody care.

I would like to see an improved protocol which will avoid the confusion as to responsibilities of Custody Sergeant and FME in relation to 'call-outs' that I have outlined above.

I am further satisfied that Mr Malone's death came as a shock to the custody staff concerned and that it was greatly regretted by all who gave evidence at this Inquiry. Those Custody staff who knew Mr Malone did not display any animosity towards him despite his behaviour whilst in custody. It may be that they allowed their prior knowledge of him to cloud their judgement which, applied more objectively, would have determined that he was a drug abuser acting irrationally, who had produced evidence of possible drug possession, which required the appropriate steps to have been taken.

Lastly, I note that Mr Malone's sister, Miss Eve Malone, and a number of family members have attended every day of this Inquiry. They have shown considerable fortitude when hearing and, in some instances, seeing, what must have been for them distressing evidence of the events which led to Mr Malone's death. I have little doubt that they did their best to support Mr Malone, who struggled to overcome his addiction during his life, and have certainly, by their continual presence supported his memory, following upon his death.

John Craig Cunningham McSherry

14 October, 2009