INQUIRY HELD AT PERTH INTO THE DEATH OF STEPHEN PARK

SHERIFFDOM of TAYSIDE CENTRAL & FIFE

DETERMINATION

by

ROBERT ALASTAIR DUNLOP, QUEEN'S COUNSEL, Sheriff Principal of the Sheriffdom of Tayside Central and Fife following an INQUIRY held at Perth on 24, 25, 26, 27, 28 and 31 March and 1 April 2003 into the death of

STEPHEN PARK

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PERTH, 25 July 2003. The Sheriff Principal, having considered all the evidence adduced, Determines:-

- In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that Stephen Park, who was born on 12 January 1974, died in Cell 4, Tayside Police Headquarters, Bell Street, Dundee between the hours of 0500 and 0625 on 21st October 2001.
- In terms of Section 6(1)(b) of the said Act, that the cause of Stephen Park's death was respiratory failure as a consequence of acute heroin toxicity.
- In terms of Section 6(1)(e) of the said Act, that the following facts are relevant to the circumstances of the death:
    - During the evening of Saturday, 20th October 2001 the deceased Stephen Park was in the company of his brother Scott Park. They had been drinking cider at the deceased's flat at 93 Nethergate, Dundee and at approximately 8 or 9 pm they left the flat with a view to acquiring a quantity of heroin. They purchased a tenner bag of heroin and returned to the flat at 93 Nethergate. Stephen Park had abused drugs, including heroin, for at least 8 or 9 months prior to that date.
    - Having returned to the flat Stephen and Scott Park prepared the heroin by mixing it with citric acid and water. Stephen Park then injected himself with a quantity of the heroin solution.
    - Following this injection Stephen Park started to look unwell and his brother Scott Park was concerned that he had overdosed on the heroin. He accordingly left the flat to telephone for an ambulance at a phone box near the flat.
    - Scott Park's telephone call to the ambulance service was received at 2204 hours. Scott Park did not disclose his identity but informed the operator that Stephen Park had possibly taken a drug overdose.
    - An ambulance was immediately despatched, crewed by John Anderson and Thomas Fleck. They were told that Stephen Park had been on drugs and was known to take ecstasy.

- The ambulance arrived at 93 Nethergate at approximately 2212 hours. Scott Park was nowhere apparent. The ambulance crew was able to gain admission to the building in which the deceased's flat was located because the entrance door had been jammed open with a cigarette packet. They found Stephen Park lying in a bedroom unconscious. They required to apply painful stimuli to his chest to revive him, which they were able to do in a matter of 2 or 3 minutes. Stephen Park denied having taken any substance and refused to go to hospital.
- At approximately 2225 hours the ambulance controller received a radio message from Mr Fleck reporting that Stephen Park refused to go to hospital and requesting the attendance of the police. The controller passed on the request to the police, who were informed that Stephen Park had taken an overdose. Three police officers, namely PC Platinga, WPC Donnelly and PC Sargeant, attended at 93 Nethergate at approximately 2235 hours. By this time they were aware that there was a warrant for the arrest of Stephen Park.
- When the police arrived at 93 Nethergate one or other of the ambulance crew indicated to them that the patient had made a miraculous recovery and that they were on the point of cancelling them. The police received the impression from what was said that the justification for their having been called to the flat had passed. When they arrived in the flat Mr Anderson was completing a disclaimer form, which was then signed by Stephen Park, acknowledging that he did not wish to go to hospital. The ambulance crew then left. At that time Stephen Park was fully conscious and alert and there appeared to be nothing wrong with him. The police were unaware that Stephen Park had been unconscious.
- Having discovered that there was a warrant outstanding for Stephen Park the police arrested him and took him to Police Headquarters, Dundee. He was presented at the charge bar where he was subjected to the standard procedures for being taken into custody. Part of that procedure involved an assessment of his vulnerability by the custody sergeant. At the material time Sergeant Smith was the custody sergeant. She was not informed that Stephen Park had been reported as possibly having taken a drug overdose nor was she aware that he had been unconscious. She assessed him as vulnerable and directed that he be subjected to a regime of half-hourly checks. He was then placed in Cell 4. During the remainder of the night he was subjected to a number of checks at varying intervals by the custody care assistant, Constable John Sergeant, who had also been involved in his arrest.
- Crown production 1 contains an accurate record of the times at which Stephen Park was checked. The entries at 0430 hours and 0500 hours are false with regard to the response received.
- Crown production 2 is the guidance document of Tayside Police for prisoner welfare, care and security. It sets out the policy and guidelines to be followed by those responsible for the custody and care of prisoners. In accordance with this policy there was a requirement for regular checks on prisoners and that a verbal response be obtained on every visit.
- At 0430 hours on Sunday 21 October 2001 Constable John Sergeant checked Stephen Park in his cell and when he asked whether he was all right received a grunt by way of response. He checked him again at 0500

hours but received no response. Stephen Park was showing signs of breathing however and Constable Sargeant was satisfied that he was all right. Having failed to secure a verbal response, observance of the proper procedure would have required Constable Sargeant to enter the cell to check more closely on the prisoner.

- At 0540 hours Constable Sargeant returned to check on Stephen Park but was again unable to obtain any response. Stephen Park was lying on his left side on the mattress with his head facing the wall. It appeared to Constable Sargeant that he had not changed his position since he checked him at 0500 hours and this caused him concern. Accordingly he entered the cell in the company of Sergeant Smith and found Stephen Park to be unconscious. Attempts were made to discover whether he had a pulse. There were no signs of life and an ambulance was called.
- The ambulance arrived at 0547 hours. The ambulance crew examined Stephen Park but found no signs of life. At 0625 hours Stephen Park was examined by Dr Sadler and Professor Pounder and pronounced dead. Later examination of the mattress on which Stephen Park had been lying disclosed the presence of mucous secretions at the side of the mattress next to the wall.
- A post mortem examination of Stephen Park was carried out by Dr Sadler and Professor Pounder on 21 October 2001. The examination revealed approximately eight discernible needle puncture marks to the right arm and an apparently fresh tourniquet mark across the upper arm. There was fresh bruising beneath one of the needle punctures in keeping with recent intravenous drug injection. There was a small amount of dried yellow collapsed foam at the right angle of the mouth. There was minor bruising to the right eye and a bruise to the middle of the back. There was a patterned abrasion to the left side of the chest wall, which appeared to have occurred after death and was consistent with attempted resuscitation. There was no trauma, internal injuries or natural disease found which could account for death. Pending toxicological analyses death was presumed to be drug related and a death certificate issued to that effect. The findings of post mortem examination are contained within Crown production 7.
- Blood and urine samples from Stephen Park were analysed for the presence of various substances and the result of such analyses are set out in two forensic toxicology reports (Crown productions 4 and 5). There was a slight positive finding of opiates in the urine sample and a finding of 0.017 milligrammes of morphine per litre of blood in the blood sample. Morphine is the active component of heroin.
- Following receipt of the toxicological report Dr Sadler and Professor Pounder recommended a change to the certified cause of death from "Presumed drug related" to "Undetermined." Their reason for doing so was that they did not wish to close off the investigative process, including the fatal accident inquiry. But for the fact that Stephen Park had died in custody the cause of death would have been certified as "acute heroin toxicity."

NOTE:

- **Parties represented at the Inquiry**

[1] In this Inquiry evidence was presented on behalf of the procurator fiscal by Mr Wheelan. Mr Carruthers, Advocate, appeared for Lisa Park, the widow of the deceased; Mr Beardmore, Advocate, appeared for Robert Park, the father of the deceased; Mr Reid, Solicitor, appeared for the Chief Constable of Tayside Police; Mrs Bennie, Solicitor, appeared for Constable Sargeant and Mr Vaughan, Solicitor, appeared for WPC Donnelly and PC Platinga.

- **Legal Framework**

[2] The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that a public inquiry should be held into the death of any person held in legal custody. The reasons for making such Inquiry compulsory are obvious. It is clearly appropriate that, where somebody has been deprived of his or her freedom by legal process and then dies while in custody, a court should investigate the circumstances of the death in public.

[3] The purpose of the Inquiry is defined in Section 6(1) of the Act, which is in the following terms:-

"At the conclusion of the evidence and any submissions thereon ... the sheriff shall 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;

- the cause or causes of such death and any accident resulting in the death;
- the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- any other facts which are relevant to the circumstances of the death."

[4] In terms of the Act the procurator fiscal has the responsibility in the public interest of investigating the circumstances of the death and placing before the court evidence bearing upon those circumstances. This procedure accordingly allows the circumstances surrounding a death to be brought under judicial and public scrutiny. It should be emphasised however that the Sheriff shall make a determination in relation to each of the matters in section 6(1) only so far as the circumstances have been established to his satisfaction. The Court can only proceed on the basis of the evidence placed before it and should not speculate about whether other circumstances exist which have not been raised in the evidence. It is with these considerations in mind that I have confined my determination to the circumstances set out in sections 6(1)(a) and (b), together with a narrative of the essential facts relevant to the circumstances of the death of Stephen Park in terms of section 6(1)(e).

- **Factual Circumstances**

[5] The essential features of the sequence of events leading to the death of Stephen Park were not really in dispute and accordingly I do not propose to dwell on the evidence that underlies all the findings in fact that I have made. However there are

some chapters in the evidence which were controversial or which in any event require more detailed elaboration.

- **Stephen Park's self-injection of heroin**

  [6] The activities of the Park brothers prior to Stephen Park becoming unwell are largely to be discovered from an account of events given by Scott Park when interviewed by the police at 1325 hours on 23 October 2001. The transcript of that interview forms Crown production 9. Scott Park was not led as a witness and the procurator fiscal rightly submitted that in these circumstances I should treat the hearsay evidence derived from this interview with caution. Nevertheless he submitted that I could place reliance on the accuracy of what was said when it was tested against other evidence. In relation to the taking of alcohol for example, Scott Park's account was corroborated, firstly, by the evidence of PC Platinga and WPC Donnelly, who smelled alcohol on Stephen Park's breath and, secondly, by the admission of Stephen Park when he was at the charge bar in police headquarters that he had had "quite a bit" to drink. Furthermore, other features of the account given by Scott Park, such as the jamming open of the door at 93 Nethergate, the time of arrival of the ambulance and the removal of the instruments used for injecting the heroin, were all consistent with other evidence. Finally there was evidence of a toxicological analysis that showed that Stephen Park had indeed taken heroin as well as a post mortem finding of a fresh track mark and signs of a tourniquet having been applied, each consistent with recent injection. In these circumstances he submitted that I could be satisfied that the general tenor of Scott Park's statement was accurate. I agree and accordingly I have reflected that evidence, so far as material, in findings in fact 3.1 to 3.4.

- **The dealings between ambulance crew and police**

  [7] In relation to the events thereafter there was some controversy. One area of conflict was to be found in the dealings of the ambulance personnel with the police and in particular what information, if any, had been imparted to the police when they arrived at 93 Nethergate. The significance of this controversy is that it has a bearing on the manner in which the police procedures in relation to the custody of prisoners should be implemented. Both ambulance crewmen were adamant that the police had been told that Stephen Park had been unconscious. On the other hand the police were entirely consistent amongst themselves in denying this. Their position was that when they arrived they were told that the patient had made a miraculous recovery and that the ambulance crew had been on the point of cancelling them.

  [8] All parties at the Inquiry recognised that the resolution of this conflict was difficult, since there was no apparent ground for thinking that the credibility of any witness was in issue. I share this view. On the other hand, so far as issues of reliability are concerned, I have come to the view that the police evidence was generally more reliable. The circumstances of this night, ending as it did with a death in custody, were of some significance to the police force generally and must have caused the police officers directly involved to reflect carefully in the immediate aftermath on their involvement in those circumstances. Accordingly I

think it likely that their recollection can generally be accepted as reliable. By contrast, the incident perhaps did not have the same significance for the ambulance crew and there are other indications that their evidence was not wholly reliable. For example Mr Fleck admitted to poor recollection of certain events and was at times hesitant in expressing a clear view. I do not attach criticism to him in that regard, given the lapse of time since the incident, but it suggests that I should exercise some caution before accepting his evidence.

[9] Furthermore there were inconsistencies between the ambulance crewmen. On the one hand Mr Fleck was insistent that Stephen Park should have been taken to hospital and that his desire to secure that end had been made clear to the police officers. The force of that evidence was somewhat diminished however when it became clear in cross-examination that he personally had had little communication with the police and that most of what he imagined must have been said on this issue would have been said by My Anderson, possibly while he, Mr Fleck, was engaged in moving equipment back down the stairs. He accepted that Mr Anderson had taken the lead in dealing with Stephen Park. On the other hand, Mr Anderson was of the view that, by the time the police had arrived, Stephen Park had indeed made a miraculous recovery and there was no need to take him to hospital. Mr Anderson went so far as to accept that somebody, probably him, might have said that Stephen Park had made a miraculous recovery and that they were on the point of cancelling the police. Mr Fleck also had a vague recollection that a reference had been made to a miraculous recovery and even that he personally may have said something to that effect. He could not recollect however any reference being made to cancelling the police. The evidence of all three police officers however appears to attribute those comments to the person who met them at the entrance, which seems more likely to have been Mr Fleck.

[10] I agree with the submissions of the parties that who said what and when is not entirely clear. What I am clear about however is that, on a balance of probabilities, the picture that was presented to the police on their arrival was that Stephen Park had indeed made a miraculous recovery and that the reason for their having been called by the ambulance crew had passed. The only basis for their continuing interest therefore was the existence of a warrant for his arrest and but for that interest they would have left him at the flat.

[11] It was suggested in closing submission that, having been summoned to assist the ambulance crew, it was inconceivable that the police would not have asked for details of what had occurred and why it was that they had been summoned. In my view however that submission does not give proper recognition to the circumstances that confronted the police. No doubt when the police were summoned the ambulance crew did want to secure the patient's transfer to hospital, but by the time the police arrived there had been a "miraculous recovery" and, rightly or wrongly, Mr Anderson at least was willing to accept that there was no need for him to go to hospital.

[12] This view is reinforced by the evidence of the police that when they arrived in the flat Mr Anderson had already embarked on completion of the disclaimer form (part of Crown production 20) by which Stephen Park acknowledged that

he did not wish to go to hospital. Some indication that that was so is to be derived from the contents of the disclaimer form which shows the apparent time of signature as 2235 hours, which was approximately the time at which, according to PC Platinga, the police had arrived. Mr Anderson's recollection was that he had been at the main door at street level when the police arrived and that they had all gone up to the flat together and that it was only at that stage that he had completed the form. However he does not have the support of any other witness in that respect and in my view he was mistaken. He also said that when he had arrived back in the flat with the police he had spoken to Stephen Park again, explaining the presence of the police and indicating a hope that the police would convince him to go to hospital. This account however is inconsistent with the view, which he had already expressed, that by that stage there was no need for Stephen Park to go to hospital.

[13] Looking to the evidence as a whole I have come to the view that the police evidence on this issue is to be preferred. If the evidence with regard to the time of completion of the form and the time of arrival of the police is correct, there was not much time for any great degree of communication. Furthermore, the evidence of the ambulance despatcher, Lesley Roft, was that the ambulance crew was clear of the building by 2240 hours and this is confirmed by the Ambulance Control Room Printout (Crown production 19), which records the precise time as 2240 hours 39 seconds. Given the evidence of the police, which I accept, it seems difficult to understand why Mr Anderson would have embarked on the completion of the disclaimer form if he still had in view that the police might persuade Stephen Park to go to hospital. Accordingly I am satisfied that by that stage there was an acceptance that Stephen Park was not going to hospital and that, in all probability, there was some reference to the ambulance crew being on the point of cancelling the police. Given the evidence of Professor Pounder, to which I will refer later in a different context, this was not an altogether unsurprising outcome.

[14] In that state of affairs it is understandable that there might not have been any exchange of information and accordingly I can credit the evidence of the police officers that nothing may have been said about Stephen Park having been unconscious. It is also worth noting that in the Patient Report Form (Crown production 20), completed by the ambulance crew, no mention is made of Stephen Park having been unconscious. The purpose of this form was primarily to inform hospital staff of the salient features of the patient and his condition on admission to hospital and of course he was not taken to hospital. But the absence from this form of any complete account of the involvement of the ambulance crew lends weight to the suggestion that, by the time of its completion, the incident had become a non-event. I do not think however it is necessary to reach a firm conclusion on this matter. In the final analysis, whether it was a case of nothing having been said or whether it was a breakdown in communication in a situation that was no longer acute, I am at least satisfied that the police officers were genuinely unaware of this piece of information. I have reflected these conclusions in finding in fact 3.8.

- **The Guidance on Prisoner Welfare, Care and Security**

[15] A second matter of controversy arose in relation to the implementation of the Tayside Police procedure regarding the welfare, care and security of prisoners (Crown production 2). A key provision of that procedure is to be found in a section headed "Initial Arrest and Custody Procedures" and is in the following terms:-

"The utmost care is to be exercised when dealing with persons who are found unconscious, semi-conscious or are suspected of having taken drugs. In such cases, or where there is doubt, the prisoner should in the first instance be transferred to a hospital or, if this is not practicable, a doctor summoned to confirm fitness for detention."

[16] Immediately following that provision there is a warning that "instances have occurred where prisoners being treated as extremely drunk were in fact suffering from injury, illness or drug overdose, sometimes with fatal consequences."

[17] A further provision of importance was the requirement to carry out a vulnerability assessment which took account of matters such as the prisoner's state of sobriety, known medical condition or known drug dependency. According to Chief Inspector Kennedy, the fact that a person taken into custody has consumed alcohol does not by itself justify the assessment of that person as vulnerable. She said that 80% of persons brought into custody were under the influence of either alcohol or drugs, but that did not necessarily make them vulnerable. The assessment process took account of the fact that drink or drugs had been consumed but the question was whether that consumption put them in a position of vulnerability. It was a matter of degree - whether there was a sufficient degree of intoxication to make them vulnerable.

[18] Persons in a vulnerable condition were to be made the subject of enhanced supervision, which involved more regular checks than the normal regime of hourly checks. In accordance with the guidance document the frequency of such checks was expected to range from constant observations to intervals of up to 30 minutes as determined by the custody sergeant. Chief Inspector Kennedy said however that half-hourly checks was the normal regime for those assessed as vulnerable. It is also provided that "a distinct verbal response is to be obtained from every prisoner on each visit and the words spoken by them recorded ..."

[19] It is plain that all these provisions have some relevance in an examination of the circumstances of the death of Stephen Park.

- **The Procedure at the charge bar**

[20] The initial part of the reception into custody takes place at the charge bar and includes the assessment of the prisoner's condition by the custody sergeant and in particular whether he is either vulnerable or presents as a special risk. The procedure requires the custody sergeant to ask three questions, namely (1) "Do you suffer from an illness or injury?" (2) "Are you taking any medication prescribed or otherwise?" and (3) "Do you have any special dietary

requirements?" The prisoner is also searched. The procedure is routinely recorded on videotape.

[21] This procedure was implemented in relation to Stephen Park and a pro forma record was kept, which forms part of Crown production 1. The custody sergeant recorded on that form her assessment of Stephen Park's vulnerability. There is an inconsistency in the record, since it apparently shows that he was assessed as non-vulnerable and yet he was put on a regime of half-hourly checks. According to the evidence of Chief Inspector Kennedy a regime of half-hourly checks was not consistent with a finding of non-vulnerability. The evidence of the custody sergeant, Sergeant Smith, was not entirely clear on this matter, but looking to the evidence as a whole what seems to have happened is that Sergeant Smith had initially thought Stephen Park was not vulnerable but had then had a doubt about that and inserted the reference to half-hourly checks without changing the formal assessment of vulnerability to "high". The fact that she changed her mind was spoken to by Sergeant Smith herself, who said she had initially written down "HOURLY" for the checks but then changed it to "1/2 HOURLY".

[22] In her evidence Sergeant Smith was unable clearly to articulate why she had selected a regime of half-hourly checks. Although she could smell alcohol on Stephen Park, she did not think that he was drunk, and her decision appears to owe more to an instinctive wariness that there was something not quite right. She was not made aware by the arresting officers of the circumstances in which they had been called to 93 Nethergate and in particular she was not informed that Stephen Park had been suspected of taking a drug overdose. As none of the police were aware that Stephen Park had been unconscious it is unsurprising that she was not given that information either. As it turned out Sergeant Smith's instinctive wariness was well founded.

[23] During the evidence of PC Platinga a video recording of the procedure at the charge bar (Crown label 1) was played, from which I derived the impression that Stephen Park was slightly subdued in his demeanour. When the videotape was played again during the evidence of Professor Pounder he noted that Stephen Park was responding appropriately to questions and was able to bend down and take something from his sock unprompted. He was walking with a slightly broad gait and his speech may have been slurred. The impression he received was that Stephen Park was showing some possible signs of being under the influence of alcohol or drugs. In large measure I thought that impression was not much different from the impression received by Sergeant Smith.

- **The cell area and the duties of the custody care assistant**

[24] When Stephen Park was taken to the cell area after the reception procedure at the charge bar he became the responsibility primarily of the custody care assistant (formerly known as the turnkey), who that night was PC Sargeant. His duties encompassed both the checking of prisoners and the taking of fingerprints on a machine known as Livescan. The Livescan process typically takes about 15 minutes for each prisoner and involved transmission of data direct to the Fingerprint Bureau

of the Scottish Criminal Record Office in Glasgow. PC Sargeant undertook a number of Livescan fingerprinting of prisoners that night and had the assistance of a civilian officer Eleanor Grant in carrying out that procedure.

[25] The responsibility for Livescan fingerprinting had fallen to the charge room staff, including the custody care assistant, some time before Stephen Park's death. It was made clear by a number of senior police officers however that the over-riding responsibility of the custody care assistant was the welfare of prisoners and that that work should receive priority over all other. This priority was well known to the custody care assistants.

[26] The visits to prisoners undertaken by the custody care assistant are recorded in the prisoner custody record, which is kept at the door of each cell. This record also includes the record of the reception procedure, including the vulnerability assessment (Crown production 1). Stephen Park was visited by Inspector (now Chief Inspector) Kennedy at 0011 hours on Sunday 21 October 2001. Thereafter he was visited by PC Sargeant as the custody care assistant. The record bears to show that PC Sargeant visited Stephen Park on ten occasions before 0540 hours, which was the time when he entered the cell and found Stephen Park to be unconscious. On each of these ten occasions he has recorded that the verbal response "Yeah" was obtained from Stephen Park.

[27] In his evidence PC Sargeant admitted that the verbal response recorded for the visits at 0430 hours and 0500 hours were false. On the first of these occasions he maintained that, on asking Stephen Park whether he was all right, he had received a grunt by way of a response. On the visit at 0500 hours he had received no response at all but was able to see that Stephen Park was breathing and he was satisfied that he was all right. What caused him to be concerned on the occasion of the next visit at 0540 hours was that Stephen Park appeared to be lying in the same position as he had been lying when seen at 0500. He could get no response from him.

[28] PC Sargeant was unable to give any clear explanation for his falsification of the record let alone any reasonable explanation. Following Stephen Park's death other police officers investigated the circumstances and had no occasion to think that there was anything wrong with the prisoner custody records generally or the prisoner custody record for Stephen Park in particular. It seems clear however that the falsification of this record weighed heavily on PC Sargeant's mind because two days later he reported to a superior officer that the record in the two respects to which I have referred was in fact false. As a result of his actions in that regard he was disciplined.

[29] Not unnaturally the disclosure of this evidence caused a deep level of suspicion in the mind of, amongst others, Stephen Park's father and in cross-examination of PC Sargeant on his behalf counsel questioned whether the whole of the record might have been falsified and whether all or some of the ten visits which had allegedly been made might not in fact have been made at all. PC Sargeant adamantly denied that suggestion.

[30] Mr Beardmore did not carry this line of questioning through to a positive closing submission but it is appropriate that I should deal with it nonetheless. I am satisfied

both from the manner in which he gave his evidence and the surrounding circumstances that PC Sargeant was telling the truth in this regard. In the first place, the record plainly shows that there are longer periods than half an hour between some of the checks and if this record had been falsified in its entirety it might be thought that that obvious failing would not have been evident. In the second place, it seems clear from the evidence that the record was taken into safe custody immediately after the events which occurred at 0540 hours. If there was a need in effect to cover up for the absence of the requisite checks by the falsification of the record that need only arose in any critical sense after Stephen Park had been discovered. However PC Sargeant did not have such an opportunity. In the third place, Eleanor Grant made it clear in her evidence, which I accept, that PC Sargeant had left her at the Livescan machine on several occasions to go and do his checks.

[31] The weight of this evidence points strongly in favour of the view that PC Sargeant did indeed make the visits to Stephen Park that are recorded on the prisoner custody record and at the times there stated. The only evidence which might be thought to run counter to that conclusion is the evidence of a number of other prisoners. I did not find that evidence entirely satisfactory. One such prisoner was George McKenzie, who maintained that for a period between 0200 hours and 0500 hours he had been awake and had never been checked by any officer. As a result of his detention he had made a complaint against the police and in that connection had had sight of the custody record relating to him. He said that that record showed that he had been visited when in fact he had not. Mr McKenzie accepted that he had been drinking that night and in my view this may well have impaired his recollection. When questioned about the procedure at the charge bar he had no recollection of being asked any questions although the routine procedure would suggest that he had. Similarly his evidence that he had not been left alone with Eleanor Grant during the Livescan process was contradicted not only by PC Sargeant but also by Eleanor Grant. In these circumstances I did not find his evidence sufficiently reliable to undermine the favourable impression that I formed of PC Sargeant in giving his evidence about the checks that he undertook.

[32] I reached a similar conclusion in relation to the other prisoners who gave evidence on this matter. Michael Smith had also had a lot to drink and claimed not to have been checked very often. On the other hand, when his statement to the police was put to him by the procurator fiscal, he appeared to accept that he had been checked quite often throughout the night and that he had heard officers going to other cells checking the prisoners as well. Paul Farrell also gave a statement to the police in which he said that he thought he was checked every hour but could not say for sure as he did not have a watch. In his oral evidence he said he could not remember saying that but that it was possible he was checked during the night - he simply did not remember.

[33] I have reflected my acceptance of PC Sargeant's evidence on this matter in finding in fact 3.10.

f) The Discovery of Stephen Park at 0540 hours

[34] When Stephen Park was discovered unconscious at 0540 hours attempts were made to discover whether he had a pulse. This issue was made the subject of

particular cross-examination since, it was said, the existence of a pulse would suggest that CPR measures were not appropriate. Three police officers apparently tried to detect a pulse and there was evidence of uncertainty about whether a faint pulse had been detected or not. There is certainly no reliable evidence that a pulse was felt far let alone a continuing pulse and I think it more likely that there was none. In these circumstances I would not criticise their decision to embark on CPR procedures. Whatever the position it is clear that the commencement of CPR had no relevance to the cause of death.

- **The Cause of Death**

[35] A post-mortem examination was carried out on Stephen Park on 21 October 2001 and the findings upon that examination are contained in a report which is Crown production 7. This report was spoken to by Professor Pounder. This evidence was in no way controversial and it is unnecessary to do more than refer to the terms of finding in fact 3.15. There was nothing in the post-mortem findings which demonstrated the cause of death. As Professor Pounder put it, "we are only left with something that we couldn't see that might have killed him." That did not mean to say however that Professor Pounder was not satisfied in his own mind as to the cause of death. He explained that, from his knowledge of the circumstances surrounding the death, he was satisfied that death was due to acute heroin toxicity. When asked why in these circumstances he had ultimately certified the cause of death as "Undetermined", he made the valid point that, as this was a death in custody, a fatal accident inquiry was mandatory and that he did not want to close off the investigative process and in particular the investigation of the surrounding circumstances upon which he relied for his conclusion. Chief among these circumstances was the fact that Stephen Park had injected himself with heroin and had then become unwell. He also attached importance to the circumstances of his death.

[36] Professor Pounder explained that heroin in the body is converted into morphine, which then acts on the brain and in particular on the respiratory centre, thus depressing the normal rate and depth of breathing. The consequences of this effect can be made worse if the person is lying awkwardly so as partially to obstruct his airways. In fatal cases the body is deprived of sufficient oxygen to maintain life and death occurs primarily as a result of insufficient oxygen being provided to the brain. In such cases this will commonly occur between two and five hours after taking the heroin. This is a recognised process of death, although the circumstances in which the same quantity of heroin will have that effect in one person and not another are entirely unpredictable. Professor Pounder explained that if someone is inexperienced in taking heroin he is intolerant of the drug and may pass out and die from taking what would be a normal dose for an addict. On the other hand, if someone is experienced in taking heroin he will have built up resistance to the drug and will accordingly require to take it in greater quantities to achieve the sought after positive effect. However such persons do not build up resistance to the respiratory depressant effect of heroin at the same rate as they build up resistance to the heroin itself and accordingly the margin of safety between the quantity of heroin necessary to produce the desired effect and the quantity that will depress respiration and kill is very narrow. It was in these circumstances that Professor Pounder graphically described the injection of heroin as playing Russian Roulette with a needle.

[37] Professor Pounder explained that in this case there was no objective evidence of oxygen deprivation other than the existence of morphine and the evidence of a relatively slow dying process. The slow dying process was to be inferred from the evidence of mucous secretion from the mouth, demonstrated by the post-mortem findings of dried yellow collapsed foam at the right angle of the mouth, which coincided with the finding of mucous secretion alongside the mattress on which Stephen Park had been lying. Although death in such circumstances might be brought about by either the brain or the heart stopping to function there was no post-mortem evidence that that was the case and therefore it was much more likely that death was attributable to a problem with breathing.

[38] I have already expressed my view that Stephen Park had injected heroin into his body and that thereafter he became unwell. I have also accepted the evidence of mucous secretions found on Stephen Park and on the mattress on which he was lying at the time of his death. When these circumstances are added to the medical explanation given by Professor Pounder with regard to what was a recognised process of death in such cases I am satisfied on a balance of probabilities that the death of Stephen Park was indeed due to respiratory failure as a consequence of acute heroin toxicity.

4. Criticisms of Police Procedures

[39] The evidence subjected the police procedures in relation to the custody of prisoners to a close examination. As a result of this examination it was suggested that a number of deficiencies had been identified, which, it was submitted, could be overcome by the adoption of various reasonable precautions. The procurator fiscal focused particular attention on the fact that Stephen Park had been both unconscious and suspected of having taken drugs and that therefore, according to their own procedures, the police required to exercise the utmost care in their dealings with him.

- **Level of enquiry by police**

[40] Following Stephen Park's death, the police apparently recognised themselves that there was room for an improvement in their procedures. This led to the introduction of an amendment to the reception procedure which required the custody sergeant to ask a fourth question as part of that procedure. That question is to be put to the arresting officer and is in these terms: "Have you given **all** information regarding this prisoner including their earlier conduct, which will enable accurate assessment of their custody care arrangements?"

[41] It is plain that the application of the "utmost care" provision in relation to any prisoner is dependent on the level of police knowledge of the identified characteristics requiring that level of care and the additional question is clearly directed to an enhancement of the level of information given to the custody sergeant as the person having the responsibility for carrying out the assessment of vulnerability. It is accordingly a welcome improvement.

[42] There remains a question however as to the extent to which the police should be expected to make enquiry to discover the existence of such characteristics. It was suggested that the additional question is ineffective unless the police take steps to

inform themselves of all the relevant circumstances and in that context the procurator fiscal submitted that there should be some arrangement between the ambulance service and the police whereby a copy of the patient report form is passed to the police showing the nature and extent of the involvement of the ambulance crew with the person being taken into custody. A further suggestion advanced by the procurator fiscal was that there should be some systematic physical search of prisoners to discover whether there are any signs of drug abuse, as for example injection marks on the arm. The thrust of the submissions was that the question was not sufficiently specific to ensure proper enquiry is made.

[43] What I think can be said in relation to the additional question is that it is difficult to be prescriptive about the sort of information that should be obtained, since there will be a wide variety of circumstances which the police might encounter and it may not always be reasonably practicable to engage in the sort of exchange of information envisaged by the procurator fiscal. It seems to me that there is a danger in trying to apply a solution derived from the particular set of circumstances in this case to other, perhaps very different, circumstances without careful analysis of the implications of doing so. In the same way, in trying to devise a question that will cover every scenario that might arise, there is a danger that the question will operate as a limiting factor in the disclosure of relevant information rather than an enabling one. I am not immediately persuaded therefore that the form of the question is inappropriate.

[44] It seems to me that, in seeking to enhance the effectiveness of the question, the preferable solution is to be found in the training of police officers, so that they are able to identify, firstly, those circumstances that might have implications for the custody care arrangements that require to be put in place and, secondly, where further enquiry might be required to discover those circumstances. Again however it is difficult to see how one could be prescriptive about the extent of enquiry given the wide variety of circumstances in which the issue might arise and perhaps all that can be achieved is a heightened state of awareness.

[45] It may well turn out that the suggestions advanced by the procurator fiscal or a variant of them could be adopted and Chief Inspector Bowman appeared to accept that, if the police are summoned at the behest of the ambulance service and are then taking the person concerned into custody, there would be benefit in the systematic recording of why the ambulance crew had been there. This is just one aspect of the wider issue of the level of enquiry that could be made. It was an issue however that was by no means fully considered in the evidence and accordingly I am reluctant to do other than draw attention to it for consideration by the police and others as they see fit.

b) Duties of the custody care assistant and the level of staffing

[46] The procurator fiscal submitted that the duties of the custody care assistant should be confined to the care and welfare of the prisoners. He suggested that the evidence showed that PC Sargeant had not attended to those duties properly, as was evidenced by the erratic timing of the checks that had been carried out in relation to Stephen Park. He submitted that had PC Sargeant not been involved in the Livescan procedure he might have performed his tasks more satisfactorily.

[47] I think that it is a valid criticism of PC Sargeant that the intervals between the half-hourly checks ranged from 15 minutes at one extreme to 40 minutes at the other. The Guidance on Prisoner Welfare, Care and Security makes it clear that, in relation to those assessed as vulnerable, the interval between checks may be "up to 30 minutes" and that, whichever interval is specified, that is the minimum interval. I can well understand that there may be good reasons why a check does not take place at precisely regular intervals, but it seems to me that a deviation of the sort demonstrated by the record of checks carried out by PC Sargeant is unsatisfactory and not compliant with the guidance.

[48] I am not persuaded however that it has been shown that, as an absolute rule, the custody care assistant cannot be involved with the Livescan procedure without risk to the proper performance of his duties in relation to the prisoners. Much will depend on the numbers of prisoners and the level of staffing at any one time. Some criticism was made of the fact that on the night in question the level of staffing appeared to be below what was accepted to be the full complement of 6. Inspector Fegan explained that that was the complement one would expect to require at the busiest period of the weekend but that it was not a level of staffing that was required at all times. He emphasised that prisoner welfare, care and security was the duty that should receive priority over all other duties and that if the resources in the custody suite were found to be inadequate at any particular time the custody sergeant could request more officers to assist. Such officers would be removed from their other duties for that purpose. He was satisfied that the custody care assistant had the capacity to undertake Livescan as well as his other duties. If his primary responsibility could not be performed properly without abandoning the Livescan procedures the Livescan procedures should be left. It seems clear to me that PC Sargeant recognised that since he did leave the Livescan from time to time to carry out his checks.

[49] There are obviously some nights, and even parts of a night, that will be busier than others and I do not consider that the public interest is best served by having the custody suite fully staffed when it is not busy. The approach of the police is one of flexibility, deploying staff to meet the requirements of any particular period, recognising the paramount importance of the prisoner welfare and care arrangements. I do not find anything inherently unsatisfactory in that approach provided the correct judgments are made about the level of staffing required at any particular time to fulfil the essential care of prisoners that is required.

[50] On the night in question there was conflicting evidence about whether it was busy or not. PC Sargeant said that it was, whereas Inspector Fegan thought that a total of 20 prisoners did not suggest that it was busy. I think the position was probably best described by Eleanor Grant, who said that it was somewhere between busy and quiet, that there were short periods when they could have done with an extra pair of hands but they were not needed when one looked at the night as a whole. It may be that PC Sargeant was under a degree of personal pressure because of concerns that he had about his wife, who was unwell, and there was some evidence that Livescan was not operating as effectively and quickly as it should have. There was nothing to suggest however that these were chronic problems and the assessment of Eleanor Grant, which I accept, does not suggest that Livescan presented them with an acute problem that night. I do not consider

therefore that it has been shown that there is anything inherently wrong in the custody care assistant also having duties in relation to Livescan.

[51] If there is any conflict such as that implied by PC Sargeant's evidence, in my view that could probably be addressed most satisfactorily in the context of training. It may be necessary to reinforce the priorities of the job and to emphasise that extra officers can be called for. There is nothing in the evidence to suggest however that an assessment of the position had not been made that night and, if such an assessment had been made, that it was wrong. Nevertheless, the circumstances of this death highlight the need to be vigilant in ensuring that the level of staffing is such that the prisoner welfare and care arrangements are not compromised and that procedures are robust for achieving that end. Since the death of Stephen Park CCTV coverage of all of the cell area has been provided and there is accordingly now a means of auditing whether the custody care assistant is performing his duties in relation to the prisoners, particularly with regard to the checks. In my view this should reinforce in the mind of the custody care assistant the need to make such checks a priority in the performance of his duties.

- **Training**

[52] The procurator fiscal submitted that the custody sergeant should receive more advanced training and in relation to the reception procedure should be under a duty to make positive enquiry about any matter where there is doubt.

[53] My impression of the evidence was that the custody sergeant would ask questions beyond those prescribed if the circumstances warranted it and in this case Sergeant Smith did in fact do so. Given the importance of the assessment exercise carried out by the custody sergeant it would seem to me desirable that the custody sergeant should have some training in that skill. There was no detailed evidence about the content of the existing training course and I have no means of assessing therefore whether this recommendation is appropriate. The police may nevertheless think it worthy of consideration.

[54] What did emerge in the course of evidence was that there were a number of members of staff who had not received refresher training within the intervals prescribed. This is plainly unsatisfactory and I recommend that the police carry out an audit of their training schedules to ensure that every member of staff who serves in or may be called to serve in the custody suite has received the appropriate and up to date training.

5. Reasonable precautions - section 6(1)(c)

[55] A specific determination in terms of section 6(1)(c) of the Act can only be made if I am satisfied not only that there was a precaution that might have avoided the death but that such precaution is reasonable. In the previous section of this note I have discussed a number of ways in which it was suggested that the police procedures might be improved. It did not appear to me however that any party went so far as to suggest that the adoption of these improvements might have avoided the death of Stephen Park.

[56] The procurator fiscal submitted that the death of Stephen Park might have been avoided had PC Sargeant gone in to cell 4 when he failed to elicit a response from him at 0500 hours. This submission was adopted by both Mr Carruthers and Mr Beardmore.

[57] In light of the circumstances now known it is tempting to think that the absence of a response at 0500 hours indicates that at that stage Stephen Park was unconscious though still breathing. I have come to the view however that such a conclusion would be speculative. Indeed, when dealing with PC Sargeant's account of what he had seen at 0500 hours, Professor Pounder acknowledged that one could conclude that Stephen Park was then alive but not that he was either conscious or unconscious. It is the state of unconsciousness which would have alerted PC Sargeant to the need for medical intervention and unless there is some basis in the evidence for concluding that Stephen Park was unconscious at 0500 hours it is in my view speculative to suggest that had PC Sargeant checked the position at that time the death might have been avoided.

[58] There was no evidence to show on a balance of probabilities how long Stephen Park had taken to die. The best evidence came from Professor Pounder, who suggested it might have been a period of 10 to 15 minutes. Were that the case, an intervention at 0500 hours would only have had a prospect of saving Stephen Park if that time fell within the 10 to 15 minute period. In fact there is no way of knowing when the final fatal process commenced and accordingly it remains a matter of speculation whether Stephen Park's death might have been avoided if PC Sargeant had gone into the cell at 0500 hours.

[59] Mr Carruthers also submitted that the death might have been avoided if the arresting officers had informed Sergeant Smith that Stephen Park had been unconscious in his home 40 minutes before arriving at police headquarters. I have already set out my reasons for concluding that the arresting officers did not know that Stephen Park had been unconscious and accordingly the hypothesis upon which this submission is advanced is not made out. Even had that information been made known to Sergeant Smith however there is no clear evidence that that might have made any difference.

[60] According to the guidance given to the custody sergeant, a prisoner who has been found unconscious should in the first instance be transferred to hospital. But what would have been the likely result of such a transfer in the case of Stephen Park? Professor Pounder explained that the medical effect of morphine on the brain could be reversed by the administration of a drug called naloxone. As he pointed out however, a patient who is a drug addict and conscious would almost invariably refuse to take that drug, since it would give him immediate unpleasant withdrawal symptoms. Furthermore, as I understood his evidence, there is no compelling medical reason to give the drug if the patient is conscious. Professor Pounder thought that it was highly unlikely that Stephen Park would have been admitted to hospital had he been taken there and, in parenthesis, this perhaps casts some light on the attitude of the ambulanceman, Mr Anderson. As Professor Pounder put it - Stephen Park "is a conscious drug addict who has taken heroin. There are hundreds of conscious drug addicts who have taken heroin walking the streets - temporarily passing out is a common experience for them, or a relatively common experience for

them, so that is not grounds for hospital admission." In my view this narrative is an ample basis for thinking that the chance of admission to hospital was not very high and that was certainly the view of Professor Pounder. Stephen Park had been arrested on a warrant so there was no question of the police being able to release him before his appearance in court.

[61] The evidence to which I have just referred also raises the question whether the terms of the guidance, which seem to require transfer to hospital in any case in which a prisoner is suspected of having taken drugs, are in fact a practicable and effective solution to the high incidence of intoxication of one sort or another evident in persons taken into custody. The evidence of Chief Inspector Kennedy seemed to suggest that the resources of both the police and the hospitals were inadequate to take every person suspected of having taken drugs to hospital and the implication was that the strict terms of the guidance may not in fact have been observed. I can well understand the argument being made by Chief Inspector Kennedy, and a question may arise about the terms in which the guidance is expressed, but I do not think it can be seen as satisfactory if the established procedure is not in fact being implemented in practice. I suggest that this is a matter that could usefully be reviewed by the police.

[62] It is appropriate at this stage also to refer to the thesis of Professor Pounder that persons who are intoxicated should not be taken into custody unless it is absolutely necessary and that the judgment as to what is absolutely necessary is a judgment of social policy. He expressed the view that if a prisoner is at such risk that he requires half-hourly checks he should not be in custody at all. If he has to be in custody he suggested that the half-hourly check would not be effective unless the custody care assistant went into the cell. The latter suggestion, if adopted, would clearly have implications for the level of resources required and I have heard no evidence which would enable me to consider whether that would be a reasonable precaution. In any event, for the reasons that I have already explained, it would be a matter of speculation whether or not that step might have avoided the death.

[63] It is evident from what was said by Professor Pounder that his primary position is the subject of discussion in certain quarters both at the national and international levels. In my view however it is not a matter upon which I can properly express a view far let alone make any positive recommendation. This view would seem to accord with the view of the parties to the Inquiry, none of whom advanced any submission founded on this approach. Even if it could properly be said to be relevant to the circumstances of the death of Stephen Park there was no examination in the evidence of the implications that might flow from the adoption of Professor Pounder's approach which would enable me to make any sensible recommendation concerning it. In these circumstances I do not think that I can usefully do more than draw attention to Professor Pounder's evidence in this regard as part of a wider debate.

[64] In the foregoing circumstances I am satisfied that there is no proper basis for making any finding in terms of section 6(1)(c) of the Act.

- **Defects in system of working - s.6(1)(d)**

[65] The provisions of section 6(1)(d) of the Act make it clear that a finding in terms of this sub-section can only be made if any defect in a system of work contributed to the death. No party to the Inquiry suggested that I should make a determination in terms of this sub-section and in my view none is appropriate.

- **CONCLUSION**

[66] For the reasons that I have sought to explain, I have confined myself to what is essentially a formal determination in terms of sections 6(1)(a) and (b) of the Act. However, in the course of a rigorous examination of police procedures, a number of issues have been identified that would merit consideration by the police and I would recommend that they do so.

[67] Before leaving this matter I think it is important to remind those who may read of these proceedings that the initial act that led to the death of Stephen Park was his own decision to inject himself with a dangerous drug. The circumstances disclosed in this Inquiry, particularly those set out in paragraph 36 above, highlight yet again the folly of that sort of behaviour. Intravenous injection of heroin is an activity which is fraught with danger to the health of those indulging in it and the tragic circumstances of this case merely serve to reinforce that point of view.

[68] I have attached hereunder a list of those who gave evidence to the Inquiry and the order in which they did so.

APPENDIX

List of Witnesses who gave evidence in the Inquiry

- Lisa Jane Park, 14E Dallfield Court, Dundee
- Robert Robertson Park, 8 Strathmore Street, Dundee
- Stanley Miller, Scenes of Crime Officer, Tayside Police
- Lesley Margaret Roft, Scottish Ambulance Service, Central Division, Dundee
- Amanda Johnston McNally, Scottish Ambulance Service, Central Division, Dundee
- Thomas David Fleck, Scottish Ambulance Service, Dundee
- Daryll Platinga, Police Constable, Tayside Police
- Donald Walker, Police Constable, Tayside Police
- Gillian Donnelly, Police Constable, Tayside Police
- Fiona Smith, Police Sergeant, Tayside Police
- Alison Kennedy, Chief Inspector, Tayside Police
- Derek John Pounder, Professor of Forensic Medicine, University of Dundee
- John Sargeant, Police Constable, Tayside Police
- Robert Massie, Scottish Ambulance Service, Dundee
- Gary Brown, Police Sergeant, Tayside Police
- Michael Smith, 19 Blackness Avenue, Dundee
- Eleanor Grant, Public Enquiry Officer, Tayside Police
- Andrew Arthur Tatnill, Inspector, Scottish Criminal Records Office, Glasgow
- Alan Davie, Inspector, Tayside Police
- Scott Heron, Police Constable, Tayside Police
- George Mckenzie, 2 Piperdam Drive, Dundee

- Paul Farrell, 4 Hill Street, Dundee
- Norman Dollan Campbell, 8 Carmichael Gardens, Dundee
- Geraldine Bruce, Forensic Toxicologist, Dept. of Forensic Medicine, Dundee
- Andrew Allan, Chief Inspector, Tayside Police
- Derek Fegan, Inspector, Tayside Police
- Alexander Bowman, Chief Inspector, Tayside Police
- John McKenzie Anderson, Scottish Ambulance Service, Dundee