SHERIFFDOM OF GLASGOW AND STRATHEKELVIN AT GLASGOW

[2021] FAI 48

GLW/81313/20

DETERMINATION

BY

SHERIFF PAUL ANTHONY REID

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

JAMES McMILLAN

GLASGOW, 23 July 2021

The sheriff, having considered the information presented at the Inquiry, Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter "the Act"), that:

(a) In terms of section 26(2)(a) of the Act, James McMillan, born on 31 March 1983, died at 0556 hours on 30 May 2018 at Glasgow City Centre Police Office, Stewart Street, Glasgow;

(b) In terms of section 26(2)(c) of the Act, the cause of death was:

(1a) Coronary Artery Atheroma;

(c) In terms of section 26(2)(d) of the Act, no accident took place and accordingly no finding requires to be made;

(d) In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided;

(e) In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death;

(f) In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

The sheriff having considered the information presented at the Inquiry, Makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This Determination is made following the Fatal Accident Inquiry under the Act into the circumstances of the death of James McMillan, born on 31 March 1983, residing at […] who died within Glasgow City Centre Police Office, Stewart Street, Glasgow on 30 May 2018.

Procedural history

[2] A notice of the Inquiry was given by the Procurator Fiscal under section 15(1) of the Act on 16 October 2020. I pronounced a first order and fixed a preliminary hearing for 8 January 2021 at 10 am within Glasgow Sheriff Court, 1 Carlton Place, Glasgow, G5 9DA. On 8 January

2021 the preliminary hearing was continued on joint motion of interested parties until 4 February 2021 at 10 am again within Glasgow Sheriff Court. The preliminary hearing of 4 February 2021, due to the pandemic restrictions on hearings in person and the recent instruction of a solicitor representing the family of Mr McMillan, was continued until 1 March 2021 again within Glasgow Sheriff Court. The preliminary hearing of 1 March 2021 was adjourned by agreement of parties to allow the agent acting for the family of Mr McMillan to obtain an expert report. A further preliminary hearing was assigned for 28 April 2021 at 10am. On 28 April 2021, Ms Allan appeared on behalf of the Procurator Fiscal. Mr Reid, solicitor, appeared on behalf of the Chief Constable, Police Scotland. Mr Rodgers appeared on behalf of the witness Police Custody Security Officer (hereinafter PCSO) Ann McGuiness, and Mr Sloan appeared on behalf of the family of James McMillan. An updated rule 3.7 was lodged at the bar by the agent on behalf of the Chief Constable, which was received, without objection, and thereafter the Inquiry was fixed for 21 June 2021 at 10 am.

[3] In advance of the Inquiry all parties entered into a joint minute. This comprised some 49 paragraphs of agreement. In particular it related to 21 Crown productions, 1 Crown label and 1 production lodged by the agent acting on behalf of the family of Mr McMillan. As a result the evidence to be led at the inquiry was substantially limited.

[4] The Inquiry took place on 21 June 2021 within Glasgow Sheriff Court. The Procurator Fiscal led evidence from three witnesses. The first witness was Ann McGuinness. She was aged 60 years. She was employed as a PCSO. In that role she had been employed for a period of 28 years. Her general duties involved attending to the care and welfare of prisoners within the custodial setting of Police Scotland. This included arranging visits if appropriate, organising

meals, allowing for washing and the administration of medication. She had received training in respect of her employment, including attendance at a first aid training course approximately every 3 years. She had worked in police stations throughout the Glasgow area, including London Road, Stewart Street, Govan Police Office and Cathcart Police Station. On 30 May 2018 she was working within Glasgow City Centre Police Office, Stewart Street, Glasgow. She was employed on the night shift being 10 pm through to 7 am. She was unaware of Mr McMillan having been detained within the cell area of Glasgow Police Office. She only became aware of his presence within the police office after the incident. She was assisting a colleague with the preparation of breakfast for those within the cells. The kitchen is situated on the third floor of the building. She would deliver breakfast to those occupying cells on the first floor, then move to the second and finally the third floor. She would carry out this task shortly before 5 am. There are no cells on the ground floor of Stewart Street. Only female prisoners are situated on the third floor. She was on the second floor attending to the needs of an individual within cell 36. His breakfast was provided to him. She was with her colleague. They went to the next cell, being cell 35. They opened the hatch and then the door. Immediately she noticed something was not right with the individual within the cell. She left the cell and pressed the panic alarm. The alarm is situated outside the door. She walked to the stairs and shouted to her fellow PCSO downstairs to phone for an ambulance. She then reported the matter to the custody sergeant. She went to the nurse's room and obtained the defibrillator machine. She got in the lift and went back upstairs with the custody sergeant. Because the panic alarm had been pressed other police officers, had in response, attended to assist. Her fellow PCSO took the defibrillator from her. She left the cell because of the number of individuals therein and went

downstairs to wait for the ambulance. The ambulance arrived and she took the paramedics upstairs to the cell.

[5] The witness confirmed that there was no phone situated on floor 2. She required to communicate with her fellow PCSO by shouting downstairs. She confirmed that if she had to speak to the custody sergeant she would have had to go downstairs. The first and third floors had a phone but not floor 2. She would employ the panic alarm if she was dealing with a disruptive prisoner or a prisoner who was self-harming. She would view this as an emergency. The panic alarm announces the emergency to the entire office. On this occasion when she pressed the panic alarm other serving police officers ran to the scene.

[6] The witness had subsequently been transferred to London Road Police Office. She advised that at that station they have mobile radios which are carried by the PCSO when carrying out their duties. She was shown production 9 at page 245 which is the prisoner's contact record. She confirmed that Mr McMillan was taken to cell 35 at 3.50am on the date in question. The prisoner contact record is a sheet which comprises a written receipt of the visits to cell 35. There is one situated outside each cell. As a practice it has been in use for the last 4 or 5 years. It is positioned on a clipboard outside the cell. Whoever attends the cell is expected to update the sheet by noting their visit including the time and their identity.

[7] The witness explained that there were occasions where individuals might fail to complete the contact record. An example provided by her – when police officers might take an individual from the cell to an interview room and forget to fill in the sheet, or where the visitor is distracted from completing the record sheet.

[8] The witness operated a computer system to record the details of the individuals' attendance in the station. The system would go red itself to let the observer know that a visit was due. There was also a white board in their room upon which the PCSO might write information on. She was referred to production 8, at page 239 which is a transaction summary report. This is the report downloaded from the computer. It records any interaction with prisoners. It was suggested that she had visited cell 35 at 4.05am. She did not recall visiting Mr McMillan's cell at 4.05 am. If she had, she advised there was a possibility that she forgot to mark up the sheet. There was no reason for her to visit the cell at this time. She explained that she was usually good with marking up the sheet and could only surmise that she had visited but then had been distracted. She advised that when a visit was carried out to the cells it involved a visit to all of the cells at the same time. This was done at least once per hour. What she did was walk down one side of the cell corridor carrying out the visits to the cells on that side and walk up the other doing the same to those on that side. She advised that she always got a response from the individuals within the cells.

[9] The witness explained that when she started her shift she required to carry out a first visit immediately and thereafter the visits would be hourly normally on the hour or every half hour. When a visit has been completed the PCSO updates the computer records. There would be division of labour. Some PCSOs would do the visits and the other PCSO, who perhaps might be on light duties, would complete the records required to be put on the computer.

[10] The witness explained what a batch update was. This is where the record of visits for each of the cells is entered simultaneously in the computer. If the batch update is inaccurate and does not reflect an incident which occurred during the visit then the PCSO who carried out

the visit would update each record as appropriate when they concluded their visit. The staff had developed their own system of working in this respect.

[11] The witness confirmed that during his period of detention within the station they encountered no difficulties with Mr McMillan. She had spoken with other prisoners who advised they were unaware of any difficulties with Mr McMillan.

[12] The witness was provided with a copy of a Police Scotland memorandum being CP 21 dated 22 June 2020 which provided direction on cell checks and the recording of the visits. She advised that the practice had returned to batch updates despite the terms of this memo. She confirmed the guidance/instruction identified within the memo is not followed through by the custody staff.

[13] The witness had no recollection of radios being used at Stewart Street Police Office.

[14] The witness advised that Stewart Street could be busy. The visits were hourly. Organising the visits on the hour made it easier to remind the PCSOs that the visits were due to take place.

[15] The next witness was Graham Hannah. He was 41 years of age. He too was employed as a PCSO. He had been in that employment for 12 years. He confirmed that he was based within Glasgow and had worked in all of the police stations in the city. At present he was in London Road but had also worked in Govan and Clydebank police offices. On 30 May 2018 he was covering Stewart Street. He was carrying out administrative and light duties because of a knee injury. He was aware of the incident involving Mr McMillan.

[16] The witness explained the procedure that when the prisoner arrived within the station the PCSO dealing with the prisoner would complete a questionnaire which would identify if

there were any health warning signs. He would then be provided with that sheet. He handed the PNC check sheet to the police. He remembered Mr McMillan and recalled that he seemed to be in good spirits and that he may have had a drink. There was no cause for concern in the presentation of Mr McMillan. He became aware of the incident involving Mr McMillan when the panic alarm was set off. At the time he was working with a colleague, Phil McCallion, while Mr Grant and Ms McGuinness were in the cell block. He heard the alarm but did not go to floor 2. He told a police officer to go to floor 2. He heard Ms McGuinness shouting that an ambulance should be called for and he called for one immediately. The ambulance arrived shortly thereafter. He had no means to communicate with his colleagues on floor 2 from where he was situated. He stood at the rear of the station with the door open to allow prompt access for the paramedics. When they arrived he took them in the lift to floor 2. He was advised that the gentleman was unresponsive. He knew which cell Mr McMillan was in. When he arrived at the cell his colleague Mr Grant was performing CPR and the paramedics went in and took over.

[17] The witness confirmed during the evening he did not carry out cell checks as he was on light duties. He explained the procedure would involve a colleague saying they were going to do a cell visit. He would mark this up on the computer. He described the completion of batch updates as being a default position. At the time the practice of the PCSO was to carry out a visit once per hour. It was the normal process. It was what staff did. There was no method of communication with other PCSO if they were on the second floor. There was a telephone on the first and third floors. The cell record sheet situated on the cell door should identify the accurate time of a visit. Different offices have changed their practices and operate different

procedures for communication. The Police Scotland memo of June 2020, being CP 21, was read to him. He confirmed that he had not seen this memorandum.

[18] The witness confirmed that if he was doing cell visits he would advise his colleague that he was going to do a cell visit. He would then go round the block and carry out his cell visits and then come back. The batch update would have been carried out. If something had occurred on his round of visits he would make a subsequent entry. He was interviewed by PIRC. Normally four or six PCSO are on duty. They are all at the same level of management.

[19] The last witness for the Fiscal was Phil McCallion. He was 61 years of age, employed as a PCSO, and had been so for a period in excess of 11 years. His official place of business is London Road Police Station. On 30 May 2018 he was working within Stewart Street Police Office. He was involved in processing prisoners that night. He was aware of Mr McMillan coming in. He was involved in processing Mr McMillan. He would ask the prisoner a number of questions which would provide him with details of the health and wellbeing of the prisoner. This allowed him to assess whether or not he was a vulnerable individual. He was assessed as not being vulnerable. Mr McMillan did not wish a solicitor to be informed of his detention. He would attend to the basics and then the custody sergeant would provide the prisoner with his rights. He described Mr McMillan as being fine, compliant, cooperative and pleasant. He had no concerns about him. He asked him about any injuries and his mental and physical wellbeing and health. He had a recollection that Mr McMillan may have confirmed that he was an alcoholic. He would ascertain in those circumstances if Mr McMillan suffered any issues concerning withdrawal symptoms. He had no concerns regarding the wellbeing of Mr McMillan. He would then ascertain what cell was available. Mr McMillan was placed in a

normal routine cell for low observation. After the process was completed the witness had no more interaction with Mr McMillan. The alarm was pressed when he was at the bar area. He went up and tried to ascertain what cell was involved. He met his colleague Ms McGuinness. He observed his colleague Mr Grant performing CPR. He did not go into the cell as other individuals were there. He was asked to consider CP 8, page 305. He was shown an entry suggesting a visit. He did not recall making this visit. He would carry out cell visits normally on his own or with a colleague. They would record their visits on a form outside the cell and update the computer. He allocated Mr McMillan to cell 35. Mr McMillan was arrested for a second offence and was taken from the cell for interview. The practice of batch updates was a manner in which each PCSO dealt with the process of cell checks. In his opinion the prisoner contact sheet would be the most accurate record.

The legal framework

[20] The Inquiry was held under section 1 of the Act and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The Inquiry was a mandatory Inquiry because at the time of his death Mr James McMillan was in legal custody.

[21] Section 1(3) of the Act sets out that the purpose of a Fatal Accident Inquiry, which is to establish the circumstances of the death and consider what steps if any might be taken to prevent other deaths in similar circumstances. The Inquiry itself is an inquisitorial process. It is not the purpose of an Inquiry to establish civil or criminal liability. Section 1 also sets out the requirement that the Procurator Fiscal who represents the public interest in a Fatal Accident Inquiry must investigate the circumstances of death and arrange for the Inquiry to be held.

Summary

Circumstances of the deceased

[22] James McMillan was born on 31 March 1983. He was aged 35 years at the time of his death on 30 May 2018. He was unemployed and resided at […] with his mother. He had been in a relationship with his partner, for a period of around 2 years. He had a daughter from a previous relationship, aged 12 years old at the time of his death. The deceased had a history of alcohol dependence and had contact with the East Dunbartonshire Alcohol & Drug Service. On occasion the deceased would fail to attend at appointments arranged for him with this organisation.

[23] The medical records of the deceased were recovered and agreed by parties. These showed that the deceased had previously attended his GP on 3 August 2017 complaining of upper abdominal pain with vomiting which was yellow and acidic. Blood tests were carried out which suggested the deceased was suffering from pancreatitis, the likely cause of which being the deceased's consumption of alcohol. At the time the deceased disclosed that he was continuing to drink around 3 litres of cider per day. The GP explained that the deceased's alcohol consumption could lead to life threatening problems and advised the deceased to stop drinking alcohol altogether and to re-engage with the alcohol and drug service.

[24] At 2305 hours on 29 May 2018, Police Scotland received a report of a domestic incident that had occurred earlier in the day. The report detailed that an incident had occurred between the deceased and his partner, at the home address of the partner. Officers were requested to attend at the home address of the partner. Police witnesses did attend. It was reported by the

deceased's partner that the deceased had been abusive towards her and had damaged her mobile phone. The police officers attended at the home address of the deceased at approximately 0140 hours on 30 May 2018. The deceased was placed under arrest in terms of section 1 of the Criminal Justice (Scotland) Act 2016 and transported to Glasgow City Centre Police Office.

[25] The deceased arrived at the police office at approximately 0208 hours on 30 May 2018. He was processed on the Police National Custody system by the witness PCSO Phil McCallion at around 0232 hours and his arrest was thereafter authorised by Police Sergeant Martin Morris. The deceased was asked a number of questions in relation to his wellbeing. The deceased confirmed he had no injuries, that he had never attempted self-harm or suicide, that he did not have any present thoughts of self-harm or suicide, that he did not have any mental health problems and that he was not dependent on any drugs or substances nor had he used any drugs or substances in the preceding 24 hours. The deceased did confirm that he had consumed alcohol in the preceding 24 hours and that he was also dependent upon alcohol, consuming around 9 litres of cider daily. It was determined that he required a low level of supervision whilst in custody and it was recorded that he required only routine observation to be carried out on an hourly basis.

[26] At 0310 hours having been deemed fit to be interviewed the deceased was taken to an interview room within Glasgow City Centre Police Office to be interviewed in relation to the alleged domestic incident. The deceased declined a consultation with a solicitor prior to the interview. The interview proceeded. The deceased provided no comment responses to the questions asked. At the conclusion of the interview process the deceased was returned to the

charge bar at approximately 0325 hours and cautioned and charged in relation to a contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. He was then escorted to cell 35 located on floor 2 of Glasgow City Centre Police Office at 0350 hours by a police officer. His placement in cell 35 was documented on the prisoner contact record shown at Crown production 9.

[27] At approximately 0455 hours on 30 May 2018 witnesses James Grant and Ann McGuinness, both PCSOs, were conducting prisoner welfare checks and providing breakfast to the prisoners on floor 2 of Glasgow City Centre Police Office. On attending at the cell of the deceased the witness Grant noted that the deceased was lying on his back on the mattress within the cell with his head lying to the side. The witness Grant opened the cell door. He entered the cell and approached the deceased. He shook the deceased on the shoulders. On receiving no response he instructed his colleague to activate the panic alarm and request an ambulance immediately. The witness Grant proceeded with CPR. The deceased remained unresponsive throughout. An attempt was made to use the defibrillator on the deceased however the screen indicated an asystole rhythm (no electrical activity) in the deceased's heart which meant that the defibrillator could not be used to shock the heart. CPR continued until the arrival of paramedics.

[28] Paramedics arrived at approximately 0520 hours. They were taken to the cell of the deceased. The paramedic prepared the defibrillator. Again there was an indication on the machine of asystole rhythm meaning there was no electrical activity in the deceased's heart. CPR continued on the deceased. The deceased was cannulated and provided with a dose of adrenalin at around 0541 hours. The deceased did not respond to this. Two further doses of

adrenalin were given at 0545 hours and 0550 hours. The deceased again failed to respond to these additional doses of adrenalin. The decision was made by the paramedics for active treatment and CPR to cease. The deceased was pronounced life extinct at approximately 0556 hours on 30 May 2018.

[29] A post mortem examination was conducted on 7 June 2018 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist Dr Marjory Turner. Her examination identified the cause of death as coronary artery atheroma. The conclusion that the post mortem provided was:

> "At post mortem examination this man was seen to have foci of significant atheroma in two main coronary arteries which could account for a cardiac arrhythmia and sudden death; microscopy also showed some necrosis of this heart muscle and mark ingestion of his liver which would be in keeping with this. There was evidence of aspirated gastric contents in his airways which could be a terminal event".

Submissions

[30] Written submissions were lodged on behalf of all parties and considered carefully.

Discussion and conclusion

[31] In light of the evidence before the Inquiry and the submissions made I am satisfied that the care provided to Mr McMillan within the police custody office, as is relevant to the remit of this Inquiry, was appropriate. There was no evidence to suggest that any alternative form of supervision or intervention would have prevented the death of Mr McMillan. Indeed a report was lodged and agreed by parties on behalf of the family of the deceased. This was a report by Dr Mark Walsh dated 4 March 2021. (DP1) In his conclusion the expert confirmed there was no

way of predicting what was going to occur in the morning of 30 May and that there was no reason for the police officers to suspect that the deceased was at risk of a cardiac arrhythmia. He concludes by stating the event was not foreseeable. I am therefore content to advance that only formal findings being made.

[32] An issue was raised during the course of the Inquiry concerning the practice of the PCSO in relation to the recording of any cell visit. A practice had developed between the PCSOs that individual officers would be dispatched to carry out cell checks whilst their colleague would place information within the computer records in a fashion described as a batch update. In effect the information on the computer in relation to each individual prisoner would be updated to reflect the cell visit had occurred and that all was well. If during the actual cell visit the officer carrying out the visit encountered a difficulty then the onus was left on him when he returned to the office to update the computer by adding a separate entry. This was the practice developed for the convenience of the officers. On this occasion after the deceased had been pronounced extinct the computer recorded two further cell visits as part of the batch update process. This could not have been accurate due to the circumstances of the deceased but is reflective of the practice. No doubt this would have been distressing to members of the family of the deceased. Police Scotland were alert to the practice and have brought to the attention of the PCSOs by way of memorandum that the practice is to desist. In candour the witnesses advised that initially the practice stopped but that the practice has gradually been reinstated contrary to the official guidance issued by Police Scotland. Indeed certain of the witnesses expressed no knowledge of the memorandum. It was a matter of convenience to them. The practice has no bearing upon the circumstances surrounding the

death of James McMillan nor did it contribute thereto. Whilst I have no formal findings to make it is a matter for Police Scotland to ensure that the PCSOs are directed to carry out proper practice which would be of benefit not only to the prisoners for whom they care but also their own health and wellbeing. I would suggest they consider reiterating the direction on CP 21 and ensure it is robustly enforced. The same applies to the cell record sheet. This is situated on the cell door. Anyone who attends the cell for whatever purpose should be made aware that the completion of the detail concerning their visit is to be written down on the sheet thereby avoiding any subsequent confusion. Here there was a suggestion of a visit by a PCSO at 4.05am. That was not recalled by the PCSO herself. Greater emphasis is required to ensure that the PCSOs recognise the significance of ensuring the contact sheet is maintained and so maintained accurately. I make this as an observation rather than a recommendation given it did not contribute to the death.

[33] A separate issue was raised regarding availability and means of communication between PCSOs whilst operating within the cell block area. Glasgow City Centre Police Office comprises three floors of cells. Floors 1 and 3 have telephone communication with the office. Floor 2 where Mr McMillan was situated does not. The absence of communication on this occasion did not contribute to the death of Mr McMillan. The basic approach adopted on this occasion was for one officer to shout for another officer or to press the panic alarm. No explanation was provided as to why floor 2 was without a phone. Again it would be in the interests of the PCSO themselves if Police Scotland were to devise some form of communication between the officers themselves and their office to facilitate information being passed not only for the interests of the prisoners whom they care for but their own health and wellbeing. It

would appear that certain stations develop their own practice. An example was the provision of an electronic tablet. The witness advised they were of little use due to the absence of a strong Wi-Fi connection. There was also a suggestion that the provision of CCTV within the cell area was dated and on occasion not fit for purpose. This is another area that police Scotland need to address not only for the interests of the prisoners but for the health and wellbeing of their staff. I again make this as an observation rather than a recommendation given it did not contribute to the death.

[34] I am grateful to parties for their preparation for this Inquiry as a result of which a great deal of formal evidence was agreed and the questioning of witnesses was limited to those issues of relevance to Mr McMillan.

[35] I wish finally to conclude this Determination by expressing my sympathy to the next of kin of Mr James McMillan.