

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976**

DETERMINATION

By

ELIZABETH C MUNRO

Sheriff of Tayside Central and Fife at Dundee

In

THE FATAL ACCIDENT INQUIRY

Into the death of

KRISTOFFER BATT

Dundee July 2010

The Sheriff having considered all the evidence adduced, DETERMINES:-

In terms of Section 6(1) (a) of said Act,

that

Kristoffer Batt, born 8 February 1990, formerly residing at The Old Schoolhouse, Craichie, Forfar, Angus, died between 0706 hours and 0746 hours on 28 November 2007 in Cell 11, Police Headquarters, West Bell Street, Dundee.

In terms of Section 6(1) (b) of said Act,
that

the cause of the death of the said Kristoffer Batt was the adverse effects of heroin and diazepam whilst in police custody.

In terms of Section 6(1) (c) of said Act,
that

the reasonable precautions whereby the death of the said Kristoffer Batt might have been avoided were

- (i) the carrying out of a full body search of Kristoffer Batt when he was placed in Cell 11 at 0420 hours or thereby on 28 November 2007;
- (ii) the availability to the Custody Sergeant of information that Kristoffer Batt had admitted on previous occasions when he was in custody that he took drugs including heroin;
- (iii) the classification of Kristoffer Batt as a prisoner of high vulnerability when he was admitted to custody on 28 November 2007, thereby rendering him subject to half-hourly checks;
- (iv) the operation of a combined light/buzzer system whereby prisoners could attract the attention of a Custody Care Assistant;
- (v) the fulfilment of his duties by Stuart Lewis, Custody Care Assistant, by responding to the assistance light activated by Kristoffer Batt, by cancelling that light when appropriate and by engaging with Kristoffer Batt at 0601 hours or thereby on 28 November 2007 when the said assistance light was illuminated;

- (vi) the proper supervision of the Custody Care Assistants to ensure that requests by prisoners for assistance were being answered within a reasonable time and that Custody Care Assistants were carrying out the requisite checks properly and timeously.

In terms of Section 6(1)(e) of said Act,

that

the following facts are relevant to the circumstances of the death of the said Kristoffer Batt, namely

- (i) There requires to be an extension of the assistance light / buzzer system to rooms within the cell area which are used by the Custody Care Assistants, namely the kitchen and the Fingerprint Office, both of which are outwith the sight and sound of the current system of buzzers and lights.
- (ii) There requires to be an extension of the assistance light system to the Charge bar, in order that the Custody Sergeant on duty can readily see whether the Custody Care Assistants are responding promptly to requests for assistance.
- (iii) Persons who hand themselves into custody, for example, by surrendering to a warrant, have therefore been in a position to conceal drugs on their person before doing so and this should be a factor in deciding whether a full body search is appropriate.
- (iv) Young persons up to the age of 16 years in Scotland are classified as juveniles for the purposes of being detained in police custody, are automatically classed as “highly vulnerable” and are subject to checks at least every half hour. The European Court of Human Rights classes a young

person as a juvenile until the age of 18 years as do most EU States. Tayside Police should follow this example for the purpose of automatically classifying prisoners up to the age of 18 as highly vulnerable.

- (v) Detailed job descriptions should be drawn up for both male and female Custody Care Assistants as there is at present a complete lack of clarity regarding their individual and joint responsibilities in relation to prisoners of both sexes.

INTRODUCTION

This was a mandatory Fatal Accident Inquiry held under Section 1(i)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. The Lord Advocate was represented by Mr Robertson, Procurator Fiscal Depute, the family of the deceased Kristoffer Batt by Mr Boyle, Solicitor, Tayside Police by Mr Reid, Solicitor and Stuart Lewis, Custody Care Assistant by Ms Nunn, Solicitor.

NOTE

Kristoffer Batt

[1] The deceased Kristoffer Batt was born on 8 February 1990 and resided with his parents and two younger half-brothers at The Old Schoolhouse, Craichie, Forfar, Angus. Throughout the Inquiry, witnesses and parties' representatives referred to him as either Kristoffer or Kris. It does not seem to me to be appropriate to refer to a 17-year old boy as "Mr Batt" and accordingly he will be referred to as Kristoffer throughout this Determination.

[2] Mrs Michelle Batt gave evidence to the Inquiry and described her son Kristoffer. In general, his health had always been good and he had been very active and involved in sport when at school. He had also been in the Sea Cadets when the family lived in Arbroath. However, he had suffered from behavioural problems for many years, although it was not until he was twelve years old that any formal diagnosis was made, at the Victoria Hospital in Fife. He was found to suffer from various problems including Attention Deficit Hyperactivity Disorder (ADHD), Tourette's Syndrome, to a degree, Oppositional Defiance Disorder (ODD), a conduct disorder and a physical "tick". He was placed on medication, initially Ritalin for the ADHD and then another one which Mrs Batt could not remember. In any event she felt that the medication worked, to the extent that it calmed Kristoffer down and made him less agitated. However, when Kristoffer was placed under residential supervision by the Children's Panel, at Kibble School in Paisley, the teachers there told him he had the right not to take his medication and he had stopped doing so. This would be when he was fifteen. He did in fact do well at that establishment and took and passed Standard Grade examinations, returning home in December 2005, when he was sixteen.

[3] Mrs Batt described two incidents when Kristoffer had harmed himself, neither of which was, in her view, serious, but a manifestation of the impulsiveness which was part of his ADHD. As far as she was concerned, Kristoffer's decision to stop taking his medication had been the wrong one: he became more impulsive without anything to "take the edge off it" as she described it. Kristoffer was involved with the Police several times, both before and after he was sixteen, and he was detained in custody on many

occasions, seven of these during 2007. He had not, however, served a custodial sentence, as all periods in custody had been on remand; Mrs Batt pointed out that he had in fact been acquitted on more than one occasion.

[4] Kristoffer had been placed on probation at Dundee Sheriff Court in 2007 but this Order should have been transferred to Cupar, when the family were temporarily living in Leuchars while they were renovating their new house. According to Mrs Batt, this never happened and it was only due to the goodwill of a social worker in Dundee that Kristoffer continued to have contact with the Social Work Department. However, when he was due to appear in Court on 13 November 2007, in relation to breaching the probation order, a female social worker in Forfar interviewed Kristoffer for the purposes of preparing her Report and it was obvious to Mrs Batt, who had attended with Kristoffer, that the social worker was going to be putting in “a bad report”.

[5] Mrs Batt could not attend Court with Kristoffer but she later received a phone call from a distraught Kristoffer telling her that he had gone to Court but had left without actually appearing before the Sheriff, because his solicitor had told him he would be going to jail. He knew, and he told his mother, that a warrant had been granted for his arrest. Mrs Batt wanted him to hand himself in but he would not do so at that time. Thereafter, they discussed it on a daily basis, sometimes several times a day, whether by phone or in person.

[6] At that time, although Kristoffer had a room and most of his belongings at the family home, he was mainly staying elsewhere, sometimes with his cousin Ryan Duke and sometimes with his friend Sean Smart, in the

home of the latter's mother. Mrs Batt was not at all happy about this arrangement and said that she had actually begged Sean Smart's mother to throw Kristoffer out so that he would come home. She was of the opinion that there were illegal drugs being taken at the house in question.

27 November 2009

[7] At around 7.30 am on the morning of 27 November 2009, police officers arrived at the Batt family home, looking for Kristoffer in connection with the warrant. As they left, Kristoffer phoned and Mrs Batt told him that he had to hand himself in or she would tell the police where he was staying; it was not acceptable that he was putting his two younger brothers through this. Kristoffer said he would. Mrs Batt gained the impression that Kristoffer knew deep down in himself that he had come to a turning point and that he had to hand himself in; he genuinely did want to change and to make amends for the things he had done wrong.

[8] Later that day, Kristoffer telephoned his mother several times. He said he was going to hand himself in but not until 4 or 5 am the following morning, which he told her was the latest someone could hand themselves in and appear in court that day. Mrs Batt arranged with Kristoffer that she would take his brothers to see him at his cousin Ryan's house at around 6.30 pm. She drove her two younger sons to Ryan's house and took clean clothes and some money for Kristoffer. Kristoffer got into his mother's vehicle and spoke with her and his brothers. He did not appear to be under the influence of any substance. At one point, the three boys went into the flat where Kristoffer was staying and he changed his top. They thereafter all sat with

their mother in the vehicle for a short time and around 8.20 pm, Kristoffer said he had to go. He hugged his mother and told her he loved her, his brothers and his dad. She told him she loved him and then watched him walk away and enter the close; that was the last time she saw her eldest son.

28 November 2009 – Mrs Batt

[9] However, Mrs Batt did manage to speak to Kristoffer by telephone at around 12.30 am on the morning of 28 November when he reassured her that he was going to hand himself in. She could tell from his voice that he was scared but there was no sign, such as slurring, that he was under the influence of any substance. He said that he had got £80 or £100 from a person called Andy Gardiner, who lived at Ryan's flat, and he asked his mother to tell the police, if they asked, that she had given him the money; she refused. However, they had not said goodbye on strained terms, and she had gone to sleep feeling relieved that Kristoffer was determined to do the right thing.

[10] Mrs Batt was awakened by a call at around 4 am, from a female member of Tayside Police, telling her that Kristoffer had handed himself in and that he was fine and in good spirits. She asked this person to pass on her love to Kristoffer. She also asked what would happen as far as the warrant to apprehend Kristoffer was concerned and was told that the computer would be updated so that the police would not come to her house looking for him. Accordingly it was something of a surprise to Mrs Batt when the police arrived at around 7.30 am, again looking for Kristoffer. She told them that he was in the police station and they left.

[11] Mrs Batt then took her other sons to school and went to work. She accessed a message on her mobile phone at around 11 am from the social worker who had been responsible for Kristoffer's probation order in Dundee. She phoned back within minutes and the conversation which she graphically described was one of initial misunderstandings and eventual realisation on each side; the social worker had assumed that Mrs Batt was aware of Kristoffer's death and Mrs Batt could not make sense of what she was being told, namely that Kristoffer had died in custody. While continuing this phone conversation, Mrs Batt drove to Tayside Police Headquarters. She was, by her account, hysterical and she said that the few persons who paid her any attention showed no compassion at all; she was treated as if she was stupid. She was told that she could not see her son's body, because the cell area had been sealed off as a crime scene.

Areas of Concern for the Batt Family regarding Kristoffer's death

[12] Mrs Batt explained that she had been surprised to learn the cause of Kristoffer's death, namely that he had died as a result of the adverse effects of heroin and diazepam. Her surprise was not that Kris had taken illegal drugs but that, in particular, he had taken heroin. She had been aware, because Kristoffer had told her, that he had taken drugs such as Ecstasy and cannabis, but she did not realise that he took heroin or Valium.

[13] Mrs Batt was asked if she could tell the Court about any aspects of Kristoffer's death which particularly concerned her and which she would like the Inquiry to address. She said firstly that as a family, they did not feel that Kristoffer was totally responsible for his death; she was of the view that the

care that Kristoffer received from the time he arrived in custody was unacceptable. She also felt the way that she was informed was unacceptable as was the fact that the computer records had not been updated to show that the warrant to arrest Kristoffer had been executed, resulting in the police coming to the family home on the morning of Kristoffer's death.

[14] Further, Mrs Batt wanted the Inquiry to address the availability of the drug Narcan, to personnel in the custody suite, which could be administered to reverse the effects of heroin.

[15] Mrs Batt had been horrified to learn that Stuart Lewis, the Custody Care Assistant (Custody Care Assistant) responsible for Kristoffer's care that night, had only been disciplined for falsifying cell record sheets. She considered it to have been gross misconduct; indeed she referred to culpable homicide. In her view, Kristoffer had been clearly vulnerable, a special risk, but that had not been recognised. She also wanted to know why the computer system did not show that Kristoffer was a drug user and therefore vulnerable. Further, she wanted to know why the buzzer system in the cells was not functioning. She said that she had one particular question for Stuart Lewis, the Custody Care Assistant to whom she had referred, and that was to ask him what it was he was doing that was so important, which left him unable to do the job he was being paid to do.

[16] Mrs Batt fully accepted that Kristoffer had not been truthful when asked by the custody sergeant if he took drugs and he answered "No". He had also replied in the negative to a question about illnesses or medical conditions although he did subsequently mention ADHD. The Custody Sergeant had accordingly classified Kristoffer as of low vulnerability and requiring hourly

checks. The Custody Sergeant did not refer to any previous records regarding Kristoffer but Mrs Batt had seen the synopsis of information regarding previous occasions when Kristoffer had been in custody and she had noted that heroin had been an issue on some of these previous occasions, including one where he had received medical treatment for withdrawal symptoms relating to heroin use. She could not understand why, in these circumstances, Kristoffer was not classed as of high vulnerability.

28 November 2007 - Sean Smart

[17] As Mrs Batt had explained, Kristoffer had been staying with his friend Sean Smart for some time before his death, against the wishes of his family. Mr Smart gave evidence about the early hours of 28 November 2007, and the events leading up to the point where Kristoffer handed himself in at Police Headquarters. Mr Smart is 19 and has a girlfriend and a young child, with whom he does not reside. On 28 November 2007, he was living with his mother and his younger sister; his mother's boyfriend was also living there occasionally. Kristoffer had been staying for a couple of weeks. Mr Smart had known Kristoffer for two years or so, through Kristoffer's cousin, Ryan Duke.

[18] According to Mr Smart, he didn't really know much about Kristoffer's background although he knew that he had been in custody on remand a few times. He, Kristoffer and their friends all took drugs of what he described as the recreational variety, namely Ecstasy and cannabis. He had seen Kristoffer take both Ecstasy and cannabis, and alcohol, but not heroin. He had seen Kristoffer practically every day while he was staying with his family. He

tended not to see Kristoffer during the day, as he was with his girlfriend and child during the day, but saw him at night.

[19] Prior to Kristoffer handing himself in on 28 November, Mr Smart had not seen him for a couple of days, but had phoned him and Kristoffer had told him that he was going to hand himself in. Mr Smart had said that he wanted to see him before he did so and it was arranged that Kristoffer would come to the house, which he did, arriving at around 2 am. He had a bag of clothes with him that he was going to take down to the police station; he said he was going to be getting the jail, by which Mr Smart understood he meant that he would be receiving a sentence of imprisonment.

[20] Mr Smart was having a drink with his mother and her boyfriend when Kristoffer arrived. Initially, in evidence, Mr Smart said that Kristoffer seemed fine except that his eyes were watering and that he was “walking about fine and speaking all right”. However, the statement he gave to the police shortly after Kristoffer’s death was put to him by the Procurator Fiscal and, with some reluctance, the reason for which was not clear, but which was probably due to some misguided sense of loyalty to his deceased friend, Mr Smart agreed that what was contained in his police statement was true. In particular, he accepted that he had said to the police that Kristoffer had seemed to be “a bit wasted” and that “his eyes were totally pinned” (an expression for pinpoint pupils). He accepted that he had said to the police that he had thought Kristoffer might have been on Valium or heroin and that Kristoffer had told him a year or so before that he had taken heroin in jail. He also accepted that he had told the police, and that it was true, that he had not seen Kristoffer taking either heroin or Valium and that his appearance of looking dead tired

was what he associated with taking these drugs. He accepted that he had said to the police that when they had got to the police office, Kristoffer seemed happy and his appearance was okay, but that his eyes were closed and in Mr Smart's opinion, he still looked a bit wasted.

[21] In any event, he said in evidence that it was agreed that Mr Smart would walk with Kristoffer to the police station, in order that the latter could hand himself in by 4 am. The police station is around 10-15 minutes' walk from Mr Smart's house. On the way, Kristoffer discussed what would happen to him and said that he was facing a 3-year sentence. He said he had some drugs on him, namely heroin and cannabis.

[22] Mr Smart was somewhat vague about this aspect. but the upshot of his evidence was that he had seen the cannabis which Kristoffer had in his possession, which he had concealed "between his cheeks" as Mr Smart put it, meaning in the cleft of his buttocks. Kristoffer had taken the cannabis out and shown it to Mr Smart. He had, however, merely told Mr Smart about the heroin and Mr Smart had said to him not to be so stupid. Kristoffer had said he was taking the heroin into the jail with him, by which he meant the prison, and he was going to make a joint with the cannabis while he was in custody in the police station. At some point, however, Kristoffer had also apparently said that he would take the heroin in the police station, get himself to sleep and then go to court in the morning. Mr Smart said that he had been begging him not to do so.

[23] The Inquiry was shown CCTV footage of the outside of the police office, and, from a separate camera, the reception area of the police office. Mr Smart was asked to view that footage and comment, as appropriate. He

became very upset towards the end of the footage, where it showed him parting from his friend, and the Inquiry required to be adjourned. However, he was then able to comment on the footage and was of assistance in explaining what could be seen.

[24] Mr Smart and Kristoffer are seen on the footage at 0351 hours, arriving in the police station car park. They are then seen walking up the steps in front of the police office and entering the reception area. Mr Smart, Kristoffer and a person called Bruce Mills are seen coming out of the reception area and standing at the top of the steps. Mr Smart was very honest about the fact that they had not realised that they were being recorded by a CCTV camera until almost the end of the footage concerned. In any event, the three young men are seen standing around chatting, and Kristoffer and Mr Smart are seen to share a joint, namely a cigarette containing cannabis, which was rolled by Kristoffer.

[25] There were various instances when Kristoffer, who was wearing track-suit bottoms, had his hand either down the front of his trousers or down the back. Mr Smart explained that Kristoffer was putting the remains of the cannabis back, within the cleft of his buttocks and that when he was seen putting his hand down the front, he was making sure that the cannabis wasn't going to fall out. At one other stage when Kristoffer had both hands behind him and apparently down the back of his trousers, Mr Smart thought it was the same, namely Kristoffer making sure that what he had put there would not fall out. Mr Smart agreed with the Procurator Fiscal Depute that Kristoffer was making quite an effort to ensure that the cannabis remained where it was,

given that he was seen touching his clothing and putting his hands in the region of his buttocks several times.

[26] Mr Smart also said that Kristoffer had taken the heroin – and tinfoil – out of his pocket and had put it with the cannabis as well. However, he said he didn't actually see him place it with the cannabis, just presumed he had.

[27] Mr Smart was asked again about Kristoffer's condition when he left Mr Smart's home to go to the police station. He said that Kristoffer had not had anything to drink while he was at the house and that when he had left, he had been "walking fine, talking fine". He did, however, say in answer to a question from me that it was only Kristoffer's eyes that gave any sign that he may have taken something.

28 November 2007 – Kristoffer Batt surrenders to the warrant

[28] As indicated, the Inquiry viewed CCTV footage not only from the camera outside the Police Station, but also of the reception area, showing Kristoffer Batt handing himself in. The first member of staff with whom Kristoffer spoke was Constable James Mitchell, who was dealing with Bruce Mills, already referred to, who was also handing himself in respect of a warrant. At that time, Kristoffer and Mr Smart came to the counter, and Kristoffer gave his name and said that there was a warrant for him. He asked to go out for a cigarette and Constable Mitchell said that he could. According to Constable Mitchell, Kristoffer did not appear to be under the influence of any substance. Constable Mitchell did not have any further dealings with Kristoffer, but obtained the hard copy warrant and gave it to his colleague, Constable Lindsay Dow, in order that she could carry out the relevant checks.

[29] Constable Mitchell described to the Inquiry the procedure which applies to someone handing himself in, namely that the person will come to the counter of the Public Enquiry Office (PEO) and a member of staff will then check if the warrant is recorded on the computer system, retrieve a hard copy of the warrant and then start to fill in the form which is called an Admin 51 Custody Record Form for the person, by putting his basic details on it. The member of staff must then check two different databases, namely SCRO (Scottish Criminal Records Office) which is now called CHS (Criminal History System) and the PNC (Police National Computer). These systems give information regarding “markers”, that is warnings that the person has, for example, a history of suicidal or violent tendencies, or for taking illegal drugs, or for carrying firearms or other weapons. If any of the markers is present, the member of staff will insert the information in the form under the heading “Reason for Special Risk”. According to Constable Mitchell, the markers could relate not to actual convictions but to police intelligence that the person has/is a risk, for example, is known to abuse drugs.

[30] As at 28 November 2007, the computer database used by Tayside Police was called Integrity which was a stand-alone system and not linked to either SCRO or the PNC. Any person whose particulars had been taken by a Tayside Police Officer, whether as a witness, or as an accused or in any other capacity, would be on the Integrity database. Details of any prisoner, whether he was brought in under arrest or surrendered himself voluntarily, had to be recorded on this system. This would be done by Constable Mitchell or an equivalent member of staff. Where details regarding risk are completed by the member of staff, this is done prior to the prisoner being taken to the

custody sergeant, who would normally go over the assessment and either alter or confirm it.

[31] The Manual governing the care of prisoners at the time of Kristoffer Batt's death was held electronically on the Force intranet and police and civilian personnel dealing with prisoners were instructed to keep up to date with the content of that Manual. However, Constable Mitchell was unaware of any system ensuring that the relevant personnel did so. He himself had had training on the custody system within the Integrity database as well as on general aspects of the Integrity system. As he explained, anybody who had had prior dealings with Tayside Police would have a "nominal" page, which would be brought up when the person's name and date of birth were entered. This screen would show those and other details. If a person had not had such dealings, a new nominal page would require to be created. The nominal page should show any markers from PNC and SCRO (now CHS). Constable Mitchell explained, however, that even if there was no marker for "drugs", and a prisoner then told the Custody Sergeant that he had taken drugs, this would be entered into the Admin 51 form. However, it would not be added to the Integrity nominal page. It would not therefore become a marker on the Integrity system whereby it would automatically show up if the person became a prisoner on a subsequent occasion, and the nominal page accessed.

[32] Constable Mitchell also explained that when a prisoner is brought into custody by police officers, having been arrested by them, rather than handing himself in, any information these officers have regarding the prisoner, for example whether he has taken drugs or usually takes drugs, is recorded on the Admin 51 form; there is a specific part of that form requiring the custody

officer assessing the risk to ask the arresting officers for any information which would assist him in making that assessment.

[33] Regarding the Admin 51 forms, Constable Mitchell explained that, once the prisoner had been released or taken to court, the form relating to him would be filed in the Public Enquiry Office for at least three months, before being transferred to the Records Department. They are filed in numerical order, according to the case reference number, the number having been generated by the computer. They were rarely referred to, other than if there was some sort of complaint against the police and details required to be checked. To find the record of any person who has come into custody in the previous three months, an officer would have to check the Integrity system to find out the reference number for the custody episode and then go to the filing system to extract the numerically filed Form 51.

[34] The Form 51 is properly a set of forms, in that the set also contains a cell sheet, which is called a Form 51A, and a Form 19 which is a risk sheet. The Form 51A is stapled to the Form 51 when the prisoner is taken to his cell and is placed on a clipboard outside that cell; the Custody Care Assistant must record all visits made to the prisoner on that Form 51A.

[35] Constable Mitchell said that as at November 2007, there were two possible vulnerability markings for prisoners, namely low, where the checks done on that prisoner would be every hour at the very least, and high, which would be every 30 minutes at the very least. However there could also be more frequent observations up to and including constant observation if the sergeant decided that was necessary. According to Constable Mitchell, if a prisoner was a known drug risk but he did not appear under the influence of

drugs and during the assessment process said he had not taken drugs within the last 24 hours, he would probably be classified as low vulnerability.

[36] There was also a system of coloured discs in use, which still applies. A red disc outside a prisoner's cell has a particular connotation, namely that there is a SCRO (CHS) marker for this prisoner to the effect that he is violent or has used weapons, or that he has previous convictions for drug misuse. A blue disc means that the prisoner is vulnerable, for example if he is under the influence of alcohol or of drugs or is suicidal or has mental health issues. A yellow disc means that the prisoner has been given medication. In answer to a question by Mr Boyle, solicitor for the Batt family, Constable Mitchell agreed that the fact that there was a red disc outside Kristoffer Batt's cell did not mean that there was any danger to Kristoffer Batt but rather to others and was the result of a 'violent' or other marker obtained from SCRO and placed on the Admin 51 form in respect of Kristoffer Batt. There was no marker for Kristoffer on either the SCRO (CHS) or PNC system relating to drugs. Also in answer to Mr Boyle, Constable Mitchell accepted that it could be dangerous to rely on the word of a drug addict alone, when assessing risk.

[37] As Constable Mitchell had explained, he had handed over responsibility for Kristoffer Batt to Police Constable Lindsay Dow. On the night of 27 November, she had been standing in for a colleague who was absent and in fact she only became a permanent member of staff within the Public Enquiry Office in December 2008. She explained in evidence that on 27 November 2007, she had started her shift at 11 pm and that the team in which she was working consisted of Sergeant Kidd and Constable Mitchell, together with civilian members of staff, namely Gillian Kennedy, who was

carrying out clerical duties and the two Custody Care Assistants, who that night were Stuart Lewis and Linda Peddie.

[38] Constable Dow was responsible for starting to fill in the Admin 51 form in respect of Kristoffer Batt. Gillian Kennedy helped her by looking up the PNC and SCRO for information regarding previous convictions, pending cases, intelligence and risks. As a result of what was contained on these databases, Constable Dow wrote in the “Reason for Special Risk” that there were “SCRO markers, firearms, violent, mental ailment”. She also wrote the same words on the Admin 19 form which is at the back of the Admin 51 set of forms. This is headed “At Risk Prisoner” and it is on this form that Constable Dow or her equivalent completes basic details regarding the prisoner. She had, in fact, in the ‘Reason for Special Risk’ box, missed out a comma between the words “mental” and “ailment”, which was simply a mistake. The word “mental” refers to mental illness and the word “ailment” refers to any illness at all. As indicated, there was no marker relating to drugs. In both the Special Risk box and on the Admin 19 form, Constable Dow had also written that Kristoffer Batt appeared to be under the influence of drink or drugs on arrest. She explained that this was the conclusion she had reached, having spoken to Kristoffer Batt through the glass partition at the Public Enquiry Office counter.

[39] Constable Dow thereafter took both Kristoffer Batt and the form through to the charge bar and handed the form over to Sergeant Kidd. She remained there while Sergeant Kidd completed the remainder of the procedure relating to the Admin 51 form, at the conclusion of which Sergeant Kidd assessed Kristoffer as being of low vulnerability and cancelled his initial

decision that Kristoffer should be strip-searched. Constable Dow said that, having spent more time with Kristoffer Batt by this stage, she agreed with Sergeant Kidd's assessment. She had thought that Kristoffer's eyelids were a bit heavy but he gave an explanation that satisfied her, saying that he had not slept. In addition, it was four o'clock in the morning and she noted that he was well-balanced and able to remove his own jewellery. These factors changed her opinion regarding him.

[40] Constable Dow accepted that if she had known that it was recorded on a previous occasion in custody that Kristoffer had taken heroin, then if she had been making the assessment this information would have caused her to pause and consider. She was shown a synopsis of Kristoffer's previous custody episodes, as extracted from the relevant Admin 51 forms, and fully accepted that such information would be useful but she said she had never been asked to retrieve a previous Admin 51 form from the filing system with regard to any prisoner. I referred Constable Dow to the admission of Kristoffer Batt on 20 September 2007 and to the fact that it was recorded on the Admin 51 form for that custody episode that Kristoffer took heroin, Valium and Methadone. There were also references on the form to his suffering from ADHD and having a previous history of self-harm and to the police doctor having noted that he was a heroin addict and had depression problems. I asked Constable Dow if that form had been filed alphabetically in the Public Enquiry Office, whether it would have been simply a matter of seconds for her to have walked to the filing system and extracted it. She agreed that that was the case and that it could have then been stapled to the back of the current Admin Form 51 for everyone to see.

[41] Gillian Kennedy was the civilian clerk on duty at the charge bar that night, assisting Sergeant Kidd. She did administrative work in the Public Enquiry Office, dealing with custody cases and working with the sergeant at the charge bar. She had been doing this for approximately seven years. She was trained on the Integrity database, which in its updated form is now called UNIFI. She assisted Constable Dow by doing checks on the PNC and the SCRO systems and conveying the resulting information to Constable Dow, for the purpose of inclusion on the Admin 51 set of forms.

[42] Prior to 28 November 2007, Mrs Kennedy said that she had booked in Kristoffer once before, in September 2007, and she had in fact previously spoken to Mrs Batt, as she was the one who had on that occasion phoned her to let her know that Kristoffer was in custody. She remembered that on the previous occasion, Kristoffer had also handed himself in and she did not notice any difference in him from his appearance that night. She described him as “not a troublesome lad”. She did notice that he was what she described as “heavy” around the eyes and said that this had been the same on both occasions. He was steady on his feet, he was not slurring his words, and he was not slow to respond to questions. She remembered him being asked to remove his jewellery and his removing an earring. In her view, there was no cause for concern.

The Charge Bar and the Assessment Procedure

[43] Accordingly, Kristoffer was presented to the Custody Sergeant, Alan Kidd, with the only documentation accompanying him being the Admin 51 form, incorporating the Admin 19 At Risk Form. As previously explained,

Constable Dow had completed Kristoffer's basic details on these forms and recorded the fact that SCRO showed various markers for him, namely "firearms, violent, mental, ailment". Constable Dow had also, as previously stated, recorded on the forms, in two places, that Kristoffer appeared under the influence of drink or drugs. No information regarding previous custody episodes was available to Sergeant Kidd.

[44] The Admin 51 set of forms relating to Kristoffer Batt featured heavily in the Inquiry and were referred to frequently and by several witnesses. In order to make sense of much of that evidence, I certainly required to have sight of the forms and accordingly these are incorporated in this Determination as Appendix 1.

[45] On the basis of the information Sergeant Kidd received from Constable Dow, he initially marked on the Admin 51A cell sheet form that Kristoffer should be strip-searched. However, he described in evidence how he carried out the assessment procedure, searched Kristoffer and then changed his mind, cancelling the instruction for a strip-search. He also marked on the form that Kristoffer was of low vulnerability and therefore to be subject to hourly checks. If he had been of high vulnerability, the minimum frequency would be every half hour.

[46] The procedure carried out by Sergeant Kidd (with the assistance of Constable Dow and the civilian clerk Gillian Kennedy) was recorded on CCTV. The CCTV camera at the charge bar records both picture and sound (unlike those in the cell area, which do not record sound) and it was therefore unnecessary to rely completely on Sergeant Kidd's recollection, although he clearly remembered that morning very well. It should be noted at this stage

that all the staff at the charge bar were seen to treat Kristoffer very kindly: this was something which Mr Boyle expressed to Sergeant Kidd on behalf of the Batt family, when cross-examining him.

[47] Sergeant Kidd explained in evidence that he always read the “Statement to Prisoner” on page 1 of the forms, to the person in custody, or paraphrased it, stressing that the person must answer the questions accurately and honestly. The CCTV footage showed that he did so in relation to Kristoffer. Unfortunately, Kristoffer answered “No” to all questions, except for saying, in answer to the question regarding whether he had ever suffered any form of mental illness or disorder, that he suffered “from ADHD and other stuff”. In particular, he denied that he took drugs or was alcohol dependent, he said that he had not taken any drink or drugs that night and that he had never committed acts of self-harm or attempted suicide.

[48] As there was no other male member of staff present, Sergeant Kidd came round to the front of the charge bar and searched Kristoffer himself. He did so partly because he wanted to get closer to Kristoffer in order to make an assessment of him, given Constable Dow’s note regarding him being under the influence of drink or drugs. He had thought this would be very unusual for Kristoffer, because he didn’t think that Kristoffer took drugs. He was conscious that Constable Dow had made the note which she did, on the basis of seeing and speaking to Kristoffer through a glass partition.

[49] Accordingly, Sergeant Kidd watched carefully how Kristoffer was able to remove his jewellery, including an earring. He observed his eyes, his demeanour, his speech, and was as close as six inches away from him. At the conclusion of this procedure, he decided that he would not strip-search

Kristoffer, a decision which he said was always based on the balancing of the interests of the individual and the interests of the police. He described it as an embarrassing procedure, although some prisoners treated it as a matter of routine. Sergeant Kidd was unaware if Kristoffer had been strip-searched on any previous occasion.

[50] Anyone with a drugs conviction had to be strip-searched, according to the Prisoner Care Manual in force at the time. The section in the Manual dealing with strip-searches described the procedure (carried out in the cell) after the person had been asked to remove his clothes, as follows:-

“Where necessary to assist the search the person may be required to hold their arms in the air or to stand with their legs apart and to bend forward so that a visual examination of the genital and anal areas can be made provided that no physical contact is made with a body orifice; if body folds still prevent an open view the subject should be required to co-operate by moving the obstructing part themselves.”

[51] Sergeant Kidd described a strip-search in much the same terms and also explained that if the prisoner would not do any of these things willingly, the officer could do it forcibly. However, if it was suspected that the person had concealed something internally (e.g. in his anus), the officer would require to obtain a Sheriff’s warrant for a medical examination.

[52] As indicated, Sergeant Kidd had no information about recent episodes when Kristoffer was in custody, and he said that he was not aware that Kristoffer had any history of taking drugs. He was shown the synopsis prepared by the Fife Police Team, who investigated Kristoffer’s death. Kristoffer had been in the custody suite in Dundee on 37 occasions, 17 of

these as a juvenile (i.e. under 16). On these 17 occasions, he would automatically have been classed as “highly vulnerable” as juveniles invariably are. He had been in custody seven times during 2007 and the vulnerability marking had varied throughout 2007. Sergeant Kidd’s attention was drawn particularly to the custody episodes where Kristoffer had either admitted to drug abuse or had denied it and then been treated by the doctor for withdrawal symptoms.

[53] In particular, the custody episode of 20 September 2007 was put to him, when it was recorded that Kristoffer admitted to taking heroin, Valium and Methadone and was classed as of high vulnerability. Kristoffer was also seen by the doctor on that occasion, who noted that Kristoffer was a heroin addict with depression problems. It should be noted that on this occasion the custody sergeant was Sergeant Loudon and that Kristoffer was strip-searched, although this was not put to Sergeant Kidd as the actual Admin 51 set of forms for that custody episode was not produced until later in the Inquiry.

[54] Sergeant Kidd told the Inquiry that if any of the information regarding drug abuse by Kristoffer had been available to him, he would have carried out a strip-search, although he also pointed out that, in many cases, nothing was found during a strip-search, only for it to come to light subsequently that the person had in fact been hiding something. In any event, it would not have altered his decision regarding a low vulnerability classification, as Kristoffer did not appear to him to be under the influence of anything.

[55] Accordingly, Kristoffer was taken to a cell on the basis that he would receive hourly checks. Sergeant Kidd pointed out that there was a mistake on the pre-printed part of the Admin 51A form (cell sheet) where it said at the

top that “A verbal response must be obtained on every visit”. This actually only applied to prisoners classed as of high vulnerability, as was made clear in the Prisoner Care Manual, and not to prisoners who were subject only to hourly checks.

[56] Kristoffer was taken to the cell area by Sergeant Kidd shortly after 0412 hours. The times given at the Inquiry and in this Determination cannot be precise: a problem which bedevilled the Inquiry was that the Fife Police Investigating Team, who scrutinised and summarised all the CCTV evidence, including the footage taken by the various cameras in the cell area, found that all the CCTV times shown on all the cameras in the cell areas were inaccurate, to the extent of between 10 and 20 minutes. On average, the time was incorrect to the extent of 16 minutes. In addition, the camera covering the female cell corridor was not working.

The cell area

[57] There are 32 male cells in the cell area, which are all below ground level. However, some of them have light coming through the sky-lights, even during the hours of darkness, because the area above them is illuminated by the very bright lights on the side of the Police Headquarters building. All of the cells have artificial lights. There are four corridors of male cells, each containing eight cells. The first corridor is directly opposite the Custody Care Assistants’ Office, and is used to house prisoners classed as of high vulnerability. There are eight female cells all contained in one corridor and there are also juvenile detention rooms on the floor above. On the night of 27-28 November 2007, the maximum number of male prisoners at any one

time was 16. This was a number easily managed by one male Custody Care Assistant, according to Sergeant Kidd and other witnesses.

[58] Kristoffer was lodged in cell number 11, in the second corridor, at around 04.20 hours, by Sergeant Kidd and Custody Care Assistant Stuart Lewis. Sergeant Kidd then left the cell area and, according to his evidence, did not see Kristoffer again that night, although he visited the cell area 3 or 4 times. He left Kristoffer in the care of the one male Custody Care Assistant on duty that night, namely Stuart Lewis.

The evidence of Stuart Lewis

[59] It would be impossible to overstate the degree to which the evidence of Stuart Lewis was unsatisfactory. Even his own solicitor, Ms Nunn, in her submissions at the close of the Inquiry, accepted that Mr Lewis, in giving evidence, “did not present well”. The Inquiry had been made aware, prior to Mr Lewis giving evidence, that he had been suspended from duty after it came to light during the Fife Police investigation that he had failed to carry out checks on prisoners that night and had falsified records to the effect that he had carried out such checks. He had been the subject of disciplinary proceedings, but a decision had been taken not to prosecute him.

[60] He initially gave evidence over 2 days and it was thought that his involvement was concluded. However, the Professional Standards Department caused various enquiries to be made while the Inquiry was ongoing and it transpired subsequently that certain evidence given by Mr Lewis as to what he had been doing on the computer during his shift was untrue. I had a meeting with parties’ representatives, who had been alerted to

this information, and it was decided that a representative of the IT Department should be called first of all to explain the findings and that thereafter Mr Lewis would require to be re-called.

[61] At the conclusion of the evidence on that third day, I advised him that I considered that he may have been guilty of contempt of court and ordered him to return at a later date. I subsequently referred the matter to another sheriff, namely Sheriff Richard Davidson, to determine the question of contempt of court and he issued his decision on 11 January 2010, to the effect that he made no finding of contempt of court. His Judgment is contained at Appendix 2, for the sake of completeness.

[62] I shall therefore summarise the evidence of Mr Lewis and comment upon it in more detail in my conclusions.

[63] Mr Lewis had been employed as a Custody Care Assistant in Tayside Police Headquarters, Dundee, since 2003. He was working on a nightshift (2300-0700) on the night of 27/28 November 2007. He was the only male Custody Care Assistant and there was also a female Custody Care Assistant, Linda Peddie, on duty with him. There were, as previously stated, 16 male prisoners. He described his duties as dealing with the care and welfare of prisoners, processing them in the sense of booking them in and releasing them, ensuring they were photographed and fingerprinted where appropriate, and ordering what he described as consumable items for the cell area.

[64] He described the system of red lights which could be illuminated by prisoners seeking assistance (this was also spoken to by other witnesses). Each cell has a button which, when pressed, will illuminate a red light outside the cell. It will also illuminate a single light at the end of the corridor and on

a board of lights in the Custody Care Assistants' room. By looking at either the light at the end of the corridor or on the board in the Custody Care Assistants' room, a person can only tell that the button had been pressed in one of the cells in that particular corridor, not in which individual cell. When a Custody Care Assistant is in either the Fingerprint Office or the kitchen, he or she had no way of seeing the lights. Further, in the Custody Care Assistant's office, anyone working on the computer had his or her back to the board of lights.

[65] When Sergeant Kidd and Mr Lewis had lodged Kristoffer in his cell, he had asked for a second blanket. Shortly after that, Kristoffer illuminated his red light (CCTV time 04:10.32, real time approximately 16 minutes later). Mr Lewis responded to that light 49 minutes later. When asked what he had been doing during that period, he said he was in the Fingerprint Office, in the kitchen or somewhere else within the cell area. He was not actually fingerprinting anyone; he was probably on the computer, checking information regarding persons in custody, or looking at official e-mails. Linda Peddie was in the Custody Care Assistants' office so he could not use the computer there. Mr Lewis accepted that he had put himself in a position where he could not see the red lights and that he had neglected his duties.

[66] According to Mr Lewis' own evidence, 49 minutes was an unacceptable time interval. If a prisoner of high vulnerability illuminates his light, this should be responded to immediately or as soon as possible; for a prisoner of low vulnerability, a response time of 10 to 15 minutes is the maximum which is acceptable.

[67] When Mr Lewis did finally respond, he handed a blanket in to Kristoffer. He switched off the red light (there is a switch on the corridor wall alongside the cell door) and got a cup of water which he then handed in to Kristoffer. All this was recorded on CCTV footage, which was viewed at the Inquiry. Mr Lewis said that he spoke to Kristoffer, who was asking for some cream to put on a new tattoo on his neck. However, when it was explained to Kristoffer by Mr Lewis that it was unlikely that the sergeant would call out a nurse for that, Kristoffer accepted that and said not to bother. According to Mr Lewis, Kristoffer was “fine” and did not give him any cause for concern. Mr Lewis then made an entry on the cell sheet (he was seen doing so on the CCTV footage) namely “WATERED”. He timed it at 05.10 hours which corresponded approximately with the inaccurate CCTV timing, as adjusted.

[68] About 10 minutes after that visit, Mr Lewis came back to that cell corridor and made false entries on the cell sheets pertaining to cells 9, 10 and 15. He marked each cell sheet as the check taking place at 04.45 as the time and wrote “Is OK”. He could not put in a false entry of 04.45 on Kristoffer’s cell sheet, however, as he already had made an entry for 05.10 hours. He accepted in evidence that these three entries were false. However, even as those present at the Inquiry watched the CCTV footage which was being shown to Mr Lewis, he tried to maintain that as he walked straight up the corridor, looking neither to right nor left (except when he wrote the false entries on the cell sheets), he was somehow “glancing” into the cells. He said that he was supposed to “visually check” prisoners, but this did not necessarily mean that he actually put his face to the cell door to look through the spy-hole. He said that he could see into a cell by “glancing” through the

spy-hole as he passed. At that stage in his evidence, I pointed out to him that we (the solicitors and I) had visited the cell area the day before, and I for one could not understand what he was suggesting.

[69] Mr Lewis was shown further CCTV footage: at the CCTV time of 5:25.13, the light outside Kristoffer's cell was seen to come on. There was no sign of Mr Lewis until 05:42 when he was seen going past cell 9 and making an entry on the associated cell sheet. He admitted this entry was false, but again maintained that he had glanced into the cell, despite the fact that anyone watching the CCTV footage could see that this was patently untrue. Mr Lewis was then seen to look into cell 10 and make an entry on the corresponding cell sheet. He did not say in evidence what, if anything, he had seen.

[70] Mr Lewis then said that he had gone to Kristoffer's cell, where the light was illuminated. On the CCTV footage, he was seen lowering the hatch, looking into the cell, for 17 seconds, then writing on the cell sheet and then looking back into the cell, for 7 seconds.

[71] The time entry on Kristoffer's cell sheet was 06.01 which corresponded to the CCTV time, as adjusted. What Mr Lewis had written on Kristoffer's cell sheet was "SITTING UP – IS OK". All of the false entries referred to above consisted of the same words namely "IS OK". He insisted that the entry regarding Kristoffer was not false.

[72] Mr Lewis told the Inquiry that when he looked in, Kristoffer was sitting on the edge of the bunk, he had his feet on the floor, one hand on his knee and he was generally sitting up, straight back, not slouched. He said that Kristoffer had given him no cause for concern. At a later stage in his

evidence, he amplified his description by saying that he had seen Kristoffer pick his foot up off the floor, look at his foot and put it down again.

[73] He did not speak to Kristoffer. He could not explain why he did not, despite being pressed by me and later by Mr Boyle. Kristoffer's red light was illuminated but he could not explain why he did not ask Kristoffer what, if anything, he wanted. He said that Kristoffer did not look up when he was at the door, despite the fact that he must have heard the footsteps coming along the corridor to the cell door and the lowering of the hatch. He did not switch off the red light and could not explain why not. This left Kristoffer with no means of calling for assistance thereafter. It was suggested that Kristoffer could have shouted or banged on the door but of course he would have had to have been physically capable of doing so.

[74] After leaving Kristoffer's cell, Mr Lewis made another false entry, as admitted by him, on the cell sheet for Cell 15, although again he maintained he "glanced" in, something that was not visible to me on the CCTV footage. Again, the entry was "IS OK". Mr Lewis was thereafter lost to view. Kristoffer's red light stayed illuminated until deactivated by the next shift at 06:48 CCTV time (just after 0700 hours real time).

[75] Mr Lewis was asked why he had made all these false entries: he said it was to cover up for the fact that he was late doing his checks. He could not explain why he was late or what he was doing to make himself late.

[76] The only evidence of Stuart Lewis carrying out any work-related task, after Kristoffer was lodged in his cell, was CCTV footage which showed him firstly escorting a new prisoner to his cell at approximately 0500 hours (real

time) and releasing two prisoners between 0524 hours and 0550 hours, each separate release taking him approximately 10 minutes.

[77] Mr Lewis said that he had not spoken to his fellow Custody Care Assistant, Linda Peddie to tell her that he was leaving the cell area to go to the Charge bar to release prisoners. There appears to have been little, if any, communication between the two Custody Care Assistants that night, despite the fact they were supposed to work as a team. He agreed that his failure to tell Mrs Peddie was unacceptable.

[78] Mr Lewis was asked about how the male and female Custody Care Assistants were supposed to work together. He appeared to suggest that they were not: he said that on an odd occasion, Linda Peddie had helped him but not on that particular night and she was not supposed to help the male Custody Care Assistant, even if he was “swamped”. He accepted that he had not been under any pressure that night.

[79] On this first day of his evidence, Mr Lewis also told the Inquiry about having been made the subject of disciplinary proceedings as a result of the investigation by Fife Police and the discovery by them that he had falsified entries on the cell sheets. He advised the Inquiry that he had been given a final written warning and had been moved to duties elsewhere in the jurisdiction.

[80] Before the Court adjourned for the day, and before instructing Mr Lewis to return the following day, I told him that there were two aspects that I really needed to know about if I were to make any sense of his evidence. I told him that I wanted to know what he was doing on the computer in the Fingerprint Office because I did not understand what had taken up all that

time. Further, he had indicated earlier in his evidence that things were not quite right in his life at that time and I told him that without wishing to pry, I wanted to know if there was something which had taken his mind off his job. I asked him to think about it overnight and discuss it with his solicitor if appropriate.

[81] The following day, Mr Lewis was firstly cross-examined by Mr Reid for Tayside Police, who suggested there was a straightforward system whereby one Custody Care Assistant would advise a fellow Custody Care Assistant if he was going outwith the cell area, Mr Lewis denied being aware of this. He was pressed on something he had said earlier, that a red light could be on “for ages” and he modified this to “for some time” and then conceded that if a Custody Care Assistant was in the Fingerprint Office for up to half an hour, he should be going out into the corridor and checking for red lights. He also had to accept that any visit at all to a prisoner, not just “checks”, should be noted on the cell sheet, something he had said in evidence he did not always do.

[82] In answer to questions from his own solicitor, he said that he was not seeking to excuse those aspects of his behaviour which were unacceptable, such as making false entries and not responding timeously to Kristoffer’s assistance light. He again described work-related matters which he could have been attending to on the computer, although he did not have any specific recollection.

[83] Also in answer to his solicitor, Mr Lewis went into detail about why he looked into Kristoffer’s cell twice when he last checked him (timed at 06:01 real time): he said that it was because it was unusual for a prisoner to be

awake at that time and he wanted to make sure Kristoffer wasn't doing anything suspicious, such as trying to conceal something.

[84] Mr Lewis had intervened in such situations in the past and gave evidence about having received positive Performance Reviews in the past, from Sergeant Kidd. One of these was produced and read out to the Court, referring to the occasion when he had stopped a prisoner committing suicide. It should be noted at this stage that Sergeant Kidd, in his answers to questioning by Miss Nunn, had spoken to this Performance Review and also to another Review which referred to Mr Lewis having performed well over one of the busiest weekends in the Custody Suite for some time. Sergeant Kidd said that he had rated Mr Lewis as one of the best male Custody Care Assistants that he had.

[85] As I had indicated to him the previous day, I wanted to find out what Mr Lewis had been doing on the computer in the Fingerprint Office that night. I put it to him that there was a period of thirty-two minutes when he was not seen on any of the CCTV cameras and Kristoffer's light was illuminated. He said he was in the Fingerprint Office, on the computer, looking at who was to be fingerprinted, and updating the cell sheet and getting it ready for the next shift. He said he "could have" been looking at the Force Intranet, at Force Bulletins, or Regional Bulletins. I indicated that I did not understand "could have", given that he must have thought very carefully about that night, knowing he was liable to be facing disciplinary action. He said that he could just not recall.

[86] I then asked Mr Lewis if the computer gave him access to the Internet and he answered, "No it doesn't". I asked him if it had games on it and he

said, “Not that I’m aware of, no”. When I asked him to answer yes or no to that, he said “No”. He said he didn’t take a book or a magazine or a newspaper with him that night. He accepted that despite all these negative answers he had not checked for a red light for at least thirty minutes that night. After a further chapter of evidence, I returned to this and gave him another chance to tell me what he had been doing on the computer. He said that it all been work associated.

[87] I explained to Mr Lewis that Kristoffer’s mother had told the Inquiry about her many concerns regarding the events surrounding Kristoffer’s death and that she had a complete lack of understanding as to why, given what happened that night, Mr Lewis had simply been given a warning and transferred. I asked him if that warning had been given on the basis of mitigating circumstances which were personal to him. Mr Lewis maintained that it was due to his prior impeccable record. However, he said that he had told the disciplinary Hearing that he had pressures outside of work, and when advised that I was prepared to have the Chairman of the Hearing brought to give evidence, he advised me that he had told the Hearing that his grandfather was ill and that he had problems in his home life, but that he wasn’t trying to use these as any excuse. However, he said that he had not been thinking straight that night. Mr Lewis was allowed to go at the end of his evidence that day.

The necessity to recall Stuart Lewis as a witness

[88] However, as previously indicated, information was brought to my attention by Mr Reid, Solicitor for Tayside Police, that the evidence of Mr

Lewis, that the computer in the Fingerprint Office that night had not given him access to the Internet, was not true. The IT department had produced a printout which showed that Mr Lewis had accessed the Internet on a substantial number of occasions that night. All the interested parties were aware of the situation and it was decided that a representative of the IT Department should be called to give evidence regarding this.

[89] Accordingly, David Flavell, Regional Technical Services Manager for the Scottish Police Service, was called and explained that his role was to work on the modernisation programme in relation to the IT infrastructure at Tayside Police.

[90] In October 2007, a proxy server called Bluecoat was introduced, the purpose of which was to allow only authorised users to access the Internet and also to determine what they could access on the Internet. In other words, it was possible to block certain groups of users from accessing different kinds of sites.

[91] When it was introduced, it was understood that it would cover all employees, but there were anomalies and some users still had access to the old proxy server which had not yet been switched off. They therefore had open access to the Internet. The problem came to light when the old proxy server was shut off, in February 2008, and employees were getting in touch with the I.T. Department, saying they had lost Internet access. It would appear that Stuart Lewis had been one of the “anomalies”.

[92] Before giving the Inquiry an account of Mr Lewis’ activities on the Internet on the night of 27/28 November 2007, Mr Flavell explained the Force Information Security Policy which must be signed by any employee before he

or she has access to the network (meaning the computer system as a whole, not the Internet). Clear operational guidelines exist on the use of systems and the fact that they should be used for business purposes only. Accordingly, although Internet access was there and may not have been blocked to an individual when it should have been, everybody (as far as Mr Flavell was concerned) was aware of what the policy for Internet use was. There were and are regular reminders regarding information security on the Force Intranet, and in particular, there were reminders during the introduction phase of Bluecoat, that Internet access was monitored and what appropriate use of the Internet was, which was basically for business purposes, meaning anything which supports operational policing.

[93] Mr Flavell then explained that he had searched under Stuart Lewis' details for what he was doing on the Internet between 10 pm on 27 November 2007 and 9 am on 28 November 2007. The first access to the Internet had been at 01.24 hours. There had been certain "gaps", namely between 02.52 and 04.45 hours, between 04.54 and 05.01 hours, between 05.13 and 05.29 hours, between 05.32 and 05.44 hours and between 05.59 and 06.06 hours. However, all that meant was that Mr Lewis had not accessed a new site between those times. Indeed, it was shown that between 05.11 and 06.11, Mr Lewis had accessed several sites. Mr Flavell had printed off details which were produced to the Court. He had also printed off the graphics which had been accessed on various sites: there was only one graphic which appeared to be work-related and the majority were described as of a sporting or other nature. They included moving graphical images, of the type commonly seen on a social networking site.

[94] In summary, Mr Flavell's evidence was to the effect that there had been "frequent, almost continual, access to the Internet, with page refreshes happening in a consistent and fairly frequent manner, which would suggest that the person was there and accessing the Internet". Mr Flavell pointed out that what he could not say was that this was exclusively what the user was doing. What he could say was that the person had been using the Internet frequently and the temporary Internet files thereby created supported that conclusion.

[95] Some 2 weeks after Mr Flavell gave evidence, Mr Lewis was recalled as a witness. This time he was given the statutory warning that he was not compellable to answer questions which tended to show that he was guilty of a crime or offence. He did not refuse to answer any questions, although he might as well have done, his answers being for the most part evasive, contradictory, confusing and basically incredible.

[96] The Procurator Fiscal Depute put to Mr Lewis the number of times the Internet had been accessed by Mr Lewis on the morning of 28 November 2007, as shown in the printout provided by Mr Flavell. Mr Lewis, under questioning, admitted (with some initial reluctance) that he had accessed the Internet a minimum of 59 times. In particular, between 01.24 and 04.26 (before Kristoffer was lodged in his cell), he accessed the Internet at least 37 times; between 04.26 and 05.15 (when Kristoffer's red light was on) he accessed the Internet at least 5 times (creating 21 temporary Internet files); between 05.41 and going off shift, he accessed the Internet at least 17 times.

[97] He required to be pressed for some time by the Procurator Fiscal Depute but eventually he accepted that he had signed a form regarding

information security when he was first employed. He could not, however, remember what the form said. He stated that he would not disagree when he was told that it indicated that Internet access was limited to business purposes. He said that his understanding was that he could access anything he liked “within reason”. The only example he could provide of material he should not access was pornographic material.

[98] When asked what he had said in answer to my question two weeks previously, regarding whether there was Internet access on the Fingerprint Office computer, he said that he did not remember what he said in reply, but accepted that if he had said no, then that answer had not been true, or at least was not correct. He said that to the best of his recollection when giving evidence, he had not had Internet access because it was “given and taken away” intermittently. He could not remember having Internet access at that time but in hindsight, should have answered that he could not remember, 19 months later.

[99] His police statement was put to him. The statement had been given by him to an investigating officer on 19 December 2007, three weeks after Kristoffer’s death. He told the officer he had been using the Focus and Integrity work systems on the computer, but made no mention of the Internet. He said he wasn’t asked. He repeatedly said that when making the statement he had not recollected being on the Internet that night.

[100] At that stage, I gave Mr Lewis a warning regarding prevarication and contempt of court. When pressed again by the Procurator Fiscal Depute, he eventually agreed that it seemed a bit strange that he could not remember, particularly given what happened that night, and the fact that he was told

about it on the afternoon of 28 November 2007. He agreed that when he heard about Kristoffer's death, he would have thought about what he had been doing and about the cell sheets he had falsified. He actually said that he could not remember – hours after his shift – being on the Internet during his shift.

[101] In cross-examination, Mr Boyle also intimated his own incredulity and scepticism regarding Mr Lewis' position. Mr Lewis' replies continued to be totally unsatisfactory, for example:

Mr Boyle: "Did it go into your head immediately after the event that you had been on the Internet?"

Mr Lewis: "It could have been, yes."

I intervened shortly thereafter and a chilling piece of evidence then emerged: Mr Lewis said that when he had Internet access, he was on the Internet, every shift. That was how he spent his time, in the Fingerprint Office, where he could not see a light, where there were no buzzers and where he could not possibly do his job. As Mr Boyle said at the time to Mr Lewis, what he had just admitted had rendered most of those present at the Inquiry speechless.

[102] Mr Lewis then said that he wouldn't go in every night and make false entries and generally behave the way he did on that night. He said it was out of character and that he was shocked, when shown the evidence by his solicitor, by the amount of time he spent on the Internet that night. He didn't think he would ever have spent that amount of time any other night.

[103] Mr Lewis maintained that colleagues did the same as him, although it was pointed out that he had better be careful what he said as this had been checked and his colleague Linda Peddie did not access the Internet that night. In answer to the solicitor, he also said that Sergeant Kidd and Inspector

Brown knew that he had Internet access and that he viewed sites which were not work-related.

[104] Perhaps the most astonishing passage of Mr Lewis' evidence came about, when being questioned by his solicitor: Sheriff Davidson in his judgement (paragraph 13), regarding contempt of court, described Miss Nunn's series of questions at this point as "an act of dubious professional propriety". During the Hearing on contempt of court, Sheriff Davidson had the benefit of the transcripts of the evidence of Mr Lewis, which show clearly that Miss Nunn misrepresented earlier evidence by purporting to read from her notes something which had not been said. At the time the exchange actually took place during the Inquiry, I obviously did not have the benefit of the transcripts, but was clear in my own mind that she was wrong and instructed her to stop putting words in the mouth of Mr Lewis. My clear impression was that the exchange between Solicitor and client had been rehearsed. She asked Mr Lewis if he remembered getting a direction from me about how to answer questions at this Inquiry and he said that he had been given a direction to answer yes or no. Miss Nunn then purported to read from her notes and said, "And I have in my notes something along the lines of, 'Do not know or cannot remember will not do.' Is that your recollection?" Mr Lewis answered "Yeah" to that question. Unfortunately, the transcripts make it clear that I said nothing of the kind and accordingly I have no idea what Miss Nunn was reading from, but it certainly was not from accurate notes of what had taken place.

[105] Mr Lewis continued to maintain that he could not recall being on the Internet that night when he gave evidence nor, even more improbably, when

he gave his statement to the police. He conceded that when giving that statement, he would, by his earlier account, have been on the Internet every shift prior to being interviewed, but he said that he could not recollect what he was doing even the day before.

[106] That concluded Mr Lewis' evidence and it was at that stage that I set in train the contempt of court proceedings.

The evidence of Linda Peddie

[107] There were also various unsatisfactory aspects to the evidence of this witness who gave evidence over two days, on the second of which she was also given the statutory warning, partly because by this time it was known that Mr Lewis had been accessing the Internet for substantial periods during their shift.

[108] Mrs Peddie had been employed as a Custody Care Assistant by Tayside Police for 18 years. Her initial training was simply a question of shadowing an existing Custody Care Assistant but she said that she had been on several courses since then, including one on custody care.

[109] Latterly, she usually worked with the same male Custody Care Assistant, namely Stuart Lewis. As part of her training, she was told they would operate in teams, i.e. the male Custody Care Assistant would normally look after the male prisoners and the female Custody Care Assistant the female prisoners. But, she said, the female does 'go and give a hand' with male prisoners; for example if lights come on, she said that the female Custody Care Assistants would go and answer them. However, on the night of 27/28 November 2007, she had asked Stuart Lewis if he was needing a

hand and he had said no, because it wasn't too busy a night. At that stage, she said, there were 4 females and 14 males (2 males were admitted later). She said that the refusal of her offer by Mr Lewis would not have stopped her answering lights or attracting Mr Lewis' attention, if she had seen the lights come on. She later explained that she couldn't see the lights at the end of the male corridors if she was in the female corridor.

[110] In relation to communication between the Custody Care Assistants, she said there were no standing instructions. She was asked about a colleague leaving the cell area and said that if Stuart Lewis left, he didn't always say where he was going, and she didn't always ask. He did not tell her that night when he left to release two prisoners. She said that it was acceptable to be left on her own for 10-15 minutes. That night, she was intending to go out for her "long" break, which is 48 minutes, as she was wanting to go to Tesco to do shopping. She told Mr Lewis this.

[111] Mrs Peddie needed permission from Sergeant Kidd to go out for her long break and she went to see him at the charge bar, just as Kristoffer was being dealt with. She was given permission. She couldn't remember when she actually left or how long she was away for, but CCTV footage showed that it was for 52 minutes between 04.48 and 05.40, according to the CCTV times, which in real time meant that it was from shortly after 05.00 to approximately 05.56. She said that she was entitled to another break of 20 minutes during the shift and thought she may have taken that in the kitchen when she came back, having a bowl of cereal or something. It was a matter for the Sergeant if he wished to provide cover for her while she was out of the

building. She did not think that anyone had filled in for her that night, which meant that Stuart Lewis was on his own.

[112] On the first occasion Mrs Peddie gave evidence, she was asked about her use of the computer that night, in the Custody Care Assistants' office, which she said she had used for aspects of her work. She was not asked about Internet access (although she was when she returned for a second day of evidence). She did not remember spending any extended period of time on the computer that night.

[113] The board of lights were behind her when she was facing the computer. She would have had to turn round to see them.

[114] When it was said to Mrs Peddie that a light had gone unanswered for 49 minutes, she said that was unacceptable, but she was perhaps understandably defensive about the fact that she had been out of the building and that Mr Lewis had not attended to it. As she said, she would assume that Mr Lewis was checking all his lights. She wasn't responsible for them. She was also "surprised" when told that a light had been left on between 05.41 and 07.06. She said that if she had noticed it she would have said something to Mr Lewis. She couldn't say why she hadn't noticed it for an hour and 25 minutes; she wasn't sure but she thought she was maybe showering prisoners, fixing cups in the kitchen or doing blankets.

[115] At the conclusion of her first day of evidence, Mrs Peddie said that, although there had been no instruction issued regarding communication between and among Custody Care Assistants, she thought they were all more aware now and let each other know where they were going. She also thought

that all the Custody Care Assistants were more aware about answering assistance lights right away.

[116] Mrs Peddie resumed her evidence eight days later, and in the interim, the cell sheets relating to the four female prisoners in custody that night had been obtained. She was shown these, and also the details of when she left the cell area for her break and when she came back. Asked questions about these documents, she was unfortunately very vague in her recollection. Also again unfortunately, the CCTV camera for the female corridor had not been working that night.

[117] Mrs Peddie accepted that there was a period of 38 minutes after Kristoffer's light was first illuminated, before she went for her break, but she could not explain why she had not seen it.

[118] She also accepted that when the light came on the second time, she was out at Tesco's and returned 15 minutes after it was illuminated. It remained on until after she went off shift at 0700 hours and she could not explain why she had not noticed it during that time.

[119] She could not say, or more accurately she could not recall, what Mr Lewis was doing during these periods. She thought he was "along the corridor", but couldn't really remember. She did think he was dealing with the male prisoners. She had to concede that if she didn't notice a "male" light in the Custody Care Assistants' room, it meant that she wasn't checking the board for "female" lights either.

[120] Mrs Peddie was questioned about various alterations which had been made to the timing of checks, as recorded in the female prisoners' cell sheets. Three of the four cell sheets had alterations, but Mrs Peddie could not explain

why only one alteration was initialled by her, something she was supposed to do in respect of any alteration.. She conceded to the Procurator Fiscal Depute that it was “a shambles”.

[121] On this occasion of giving evidence, she was asked about Internet access, and said she remembered she could access the Internet at that time, as could all the Custody Care Assistants. She also recalled what she described as a “bulletin” being issued saying that the Internet was not to be misused; she thought this was issued when they first got access. She used it to get phone numbers for people if a prisoner wanted someone contacted and for other business purposes. She did not know if she had been on the Internet that night nor if Mr Lewis had been. As it turned out, the IT Department confirmed that she had not accessed the Internet during her shift that night.

[122] Mrs Peddie said that if it was a quiet night, she would find something to do, like cleaning or stock taking. She could not remember exactly what she had been doing that night.

[123] Mrs Peddie seemed genuinely taken aback and indeed distressed that she had apparently not noticed Kristoffer’s red light that night, but then said that she may have seen it and thought that Mr Lewis was dealing with it. She accepted, however, that she didn’t actually know what Mr Lewis was doing during their shift.

[124] Under a great deal of (appropriate) pressure from Mr Boyle, Mrs Peddie could not provide a satisfactory explanation for the alterations she made to cell sheets. She thought that she had perhaps written the time as being exactly an hour after the previous check and then realised by looking at the clock or her watch that she was late, so altered it to the correct time. In

fact, she had been out of the building at the times she had originally noted and then deleted. She denied that she had made false entries.

The day shift – 28 November 2007

[125] Mr Lewis and Mrs Peddie finished their nightshift at 0700 hours. The two male Custody Care Assistants on duty that day were David Massie and Alastair Smith. The custody sergeant was Gregor Stewart.

[126] Alastair Smith, who had been a Custody Care Assistant for 7 years, gave evidence that as he arrived for work, 5-10 minutes early, he met Mr Lewis in the car park, leaving work. Mr Lewis told him that David Massie was already there and that they had done the handover.

[127] Mr Smith went to the cell area, spoke to his colleague David Massie, who confirmed he had done the handover with Mr Lewis, and at 0700 hours the two Custody Care Assistants began their first checks. Mr Massie took the first corridor (cells 1-8) and Mr Smith the second (cells 9-15). The handover form would have stipulated the vulnerability level of each prisoner, as would the individual cell sheets. Mr Smith's preferred option, even with a low vulnerability prisoner, was to obtain a verbal response on the first check, even though that was not required by the Prisoner Care Manual. He would drop the hatch and speak to the prisoner, to make sure that the prisoner was okay. After the first check, he would still drop the hatch but simply do a visual check. If it was at night and dark, he would always flick the light on briefly to do his check, to make sure that someone's chest was rising and falling, if he appeared to be asleep.

[128] Mr Smith had dealt with Kristoffer Batt before. He described him as “never cheeky. He was always a cheery chap in custody”. He had previously taken him to the doctor while he was in custody, because of his drug habit. Nevertheless, he was not surprised to see that he was classed as of low vulnerability.

[129] On entering the second corridor, Mr Smith first checked cell 9, then cell 10, then cell 15, making a note on each occasion. He then went to Kristoffer’s cell and put down the hatch. He saw Kristoffer lying on his back, his face partially covered by the blanket. Mr Smith shouted “Kris” three times, getting louder each time. Kristoffer grunted and turned over onto his side. Mr Smith noted the time – 07.06 – and “Grunted” on the cell sheet. As Kristoffer’s assistance light had been on, he then looked back through the spy-hole and was satisfied that all was in order. He said that he was content with the response he got and repeated that in terms of the Manual, he did not require to obtain a verbal response. He put off the assistance light and then proceeded to do the rest of his checks.

[130] After all the checks were completed, Mr Smith and Mr Massie had to start on the breakfasts: every prisoner is offered a roll and a cup of tea. They went round together, with the trolley, taking alternate cells. It must be noted on the cell sheet whether a prisoner accepts or refuses breakfast. They reached the corridor comprising cells 9 to 15 at 07.35. The occupants of cells 9 and 10 refused breakfast; the occupant of cell 15 accepted it. The two men reached Kristoffer’s cell at 07.36. Mr Massie opened the hatch and Mr Smith wrote 07.36 and AS (his initials) on Kristoffer’s cell sheet. He heard Mr

Massie asking Kristoffer a couple of times if he wanted breakfast but there was no response.

[131] They opened the cell and went in. Kristoffer was in the same position in which Mr Smith had last seen him. He shook Kristoffer by the left shoulder and then noticed “mucousy stuff” around his mouth, which he said had spots of red in it. He checked the pulse in Kristoffer’s neck and found nothing; Kristoffer wasn’t breathing. He was however still warm and Mr Smith said that initially he was a good colour. The two men lifted Kristoffer, on his mattress, onto the floor. Mr Smith tried to clear Kristoffer’s airway but found a lot of sickness or mucous in his mouth. He used a small facial mask which he carried with him to attempt mouth-to-mouth resuscitation, while Mr Massie phoned Sergeant Stewart and told him to get an ambulance.

[132] Mr Smith then ran to get a bag, mask and valve, which he was trained to use, from the Custody Care Assistants’ office and used this in an attempt to get some air into Kristoffer’s lungs. In the meantime, one of the Court police officers had arrived on the scene and he carried out chest compressions. Sergeant Stewart also arrived, followed by the paramedics, who took over. Mr Smith remained until Kristoffer’s life was pronounced extinct.

[133] The above sequence of events, with the exception of what took place in the actual cell, was seen on the CCTV footage shown to the Inquiry.

[134] David Massie also gave evidence. He is the least experienced of the Custody Care Assistants who gave evidence, having taken up the post in October 2006. He had a whole day’s training, with a custody sergeant on a one-to-one basis, then spent a week shadowing another Custody Care

Assistant. He was subsequently trained on the Integrity computer system, which is now UNIFI.

[135] His account of the differences between high and low vulnerability was the same as that of previous witnesses in terms of checking intervals and whether a verbal response was required. He said that, during the night, it was a fine line between satisfying himself that the prisoner was okay and riling the prisoner. So Mr Massie's habit was just to flick on the light to check.

[136] He said that, as at November 2007, there was no rule (unlike the current arrangement for a half-hour overlap) regarding a handover, but each Custody Care Assistant tended to come in 10 minutes early to run through the details of high vulnerability prisoners. He had done so on this morning. There had been no reference to Kristoffer by Stuart Lewis.

[137] Mr Massie spoke about it being good practice to mark every visit on the cell sheet, although he said he had probably been guilty of not marking it up if it had just been a matter of minutes since he had carried out – and marked up – a check and this time he was just giving the prisoner toilet paper or water or something. As far as response times were concerned, he had been taught, and observed, a rule of thumb that an acceptable response time for high vulnerability prisoners would be a couple of minutes. Even if the prisoner was of low vulnerability, there was no reason for not going straightaway if you could; personally, he would not like to leave it more than 10 minutes or so.

[138] When Mr Smith arrived, Mr Massie phoned to order the breakfast, checked who required to be fingerprinted and then he and Mr Smith did their first checks. He took the first corridor which housed the prisoners of high

vulnerability. He was therefore looking for a verbal response, or someone who was obviously up and about, on the toilet or reading a book.

[139] While in the first corridor, he heard Mr Smith in the second corridor shouting “Kris!” a couple of times. Asked how loud it was, he said it was slightly above talking sort of level, loud enough for him to hear it in the first corridor. He said that when they had met up, Mr Smith had not said anything about Kristoffer’s red assistance light having been illuminated.

[140] After the checks, they started to do the breakfasts. In Corridor 9 – 15 they had gone, as Mr Smith had explained, to the other cells first. Mr Massie then went to cell 11, put the hatch down and shouted “Kris, do you want breakfast?” He believed he shouted it again. Kristoffer was lying on the bunk, facing away from him, on his side, facing the wall. He had a blanket over him. Mr Massie said to Mr Smith, “No response at all” and they opened up the cell. Mr Smith pulled Kristoffer’s shoulder. Mr Massie saw Kristoffer’s face which he described as a “sort of paste-like colour, mainly around his eyes, his nose and his mouth”.

[141] Together, they lowered him onto the floor, still on his mattress. Mr Smith checked for vital signs but Mr Massie said there was no sign of life the whole time he was there, although he touched Kristoffer and he didn’t recall him being cold. Mr Massie described the attempts by Mr Smith and the Court police officer to resuscitate Kristoffer. He described the paramedics arriving and said that he had gone away to attend to other prisoners in “a bit of a blur”.

The paramedical and medical evidence

[142] The Inquiry heard from Bruce Rumgay, a paramedic with the Scottish Ambulance Service; he has held that position for twelve years. On the morning of 28 November 2007, he was on duty with his regular partner, Rebecca Anderson, when they were instructed, at 07:38:28 to go to Police Headquarters, Dundee. They arrived at 07:46:48 and were taken immediately down to cell number 11. They were briefed on the way that there was a male unconscious and foaming or vomiting at the mouth.

[143] They found Kristoffer in Cell 11, on his back, being given artificial ventilation by Alistair Smith, who was using a bag and mask. Mr Rumgay took over as there was vomit around Kristoffer's mouth and if he had inhaled any vomit, this type of ventilation would not be effective.

[144] Kristoffer appeared unconscious and unresponsive. There were no signs of life; he was not breathing; there was no pulse. Mr Rumgay described Kristoffer as pale and cyanosed; by the latter term he meant that there was a blue tinge around his lips and ears, indicating a lack of circulation of the blood.

[145] Mr Rumgay administered cardiac resuscitation drugs, to try to stimulate some activity in the heart, which, if successful, would have meant that they could have proceeded to defibrillate or "shock" the heart into a normal rhythm. However, Kristoffer's heart showed no sign of activity.

[146] As Mr Rumgay was having difficulty gaining access to Kristoffer's airway because of vomit in the airway, his colleague Ms Anderson ran to the ambulance and brought back a suction unit for Mr Rumgay to use. In the meantime, Mr Rumgay used the defibrillator machine to check if there was any electrical activity in Kristoffer's heart and established that there was no heart rhythm at all.

[147] Mr Rumgay then used the suction unit and thereafter intubated Kristoffer, that is he inserted a tube into Kristoffer's lung. However, there was vomit coming back

up the tube which would point towards there already having been inhalation of vomit into the lungs.

[148] There was no change in Kristoffer's condition throughout the time that the paramedics attempted to resuscitate him. Mr Rumgay said that they tried everything, namely cardiac drugs, intubation, ventilation, and chest compressions. The standard guidance said that after twenty minutes of taking such measures without success, life should be presumed extinct. In fact, it was nearer twenty-five minutes in Kristoffer's case, because Mr Rumgay and his colleague lost track of time. Kristoffer was pronounced dead at 08.10 hours.

[149] Mr Rumgay was asked if he could tell how long Kristoffer had been without any signs of life, before the paramedics arrived; in other words could he tell when Kristoffer had died. He said that he thought Kristoffer was still warm when they arrived although he also said that he could not be one hundred per cent sure about that. The signs of cyanosis he had referred to – the blueness around the lips and the ears – manifest themselves fairly quickly as the body is not being oxygenated. There were definitely no signs of rigor mortis or of hypostasis, which is often called “post-mortem staining”. The latter occurs when a person has been dead for a period varying between 20 minutes and 3 hours, and is the discolouration of the skin on parts of the body, which is caused by the gravitational effect of the blood collecting inside the body, at the body's lowest point. From Mr Rumgay's lengthy experience, he estimated that Kristoffer had been in the condition in which they had first seen him for ten to fifteen minutes.

[150] When it became clear to the Senior Police Officer in charge that Kristoffer could not be resuscitated, he instructed that the Police Surgeon on duty be called out. That was Dr Magdalena Turowska, who gave evidence to the Inquiry and said that

she had arrived approximately an hour later. As at 28 November 2007, the provision of Police Surgeons was through the company Medacs and Dr Turowska said that such a delay was not uncommon. However, it was now much improved as the contract was between the Police and NHS Tayside Out of Hours Service.

[151] In any event, when she arrived, she examined Kristoffer, who was clearly dead. He was lying on his back. She found no sign of injury, for example cuts or bruises, although she did see signs of attempted resuscitation. She noted that there was hypostasis or post-mortem staining on Kristoffer's body which was consistent with his being in that position when he died or having been put in that position not long after he died. In other words, if Kristoffer had been lying on his side when he died and had lain there for some time, post-mortem staining would have been visible on that side of his body, which it was not. Dr Turowska said that hypostasis normally appears shortly after death, sometimes within minutes. She agreed that it was possible that it had developed between 08.10 when the paramedics declared Kristoffer dead and her examination of his body.

[152] Dr Turowska also said that Kristoffer's body was still relatively warm, not completely cold, indicating that he was "not very long dead". This opinion took into account that the cell was neither particularly warm nor particularly cold.

[153] Dr Turowska also spoke about the pilot scheme which commenced in January 2009, whereby two nurses employed by NHS Tayside were on duty at any given time, covering Dundee, Perth and Arbroath. A computer terminal providing access to the NHS database had been installed in the custody suite and the nurses and the Police Surgeons had access to the database; police officers did not. She saw the scheme as a significant improvement, from the point of view of being able to check a prisoner's medical history. However, she stressed that not all the prisoners were seen

by a nurse; the role of the nurse is not to provide a screening service and they only saw a prisoner if he sought medical attention or the Custody Sergeant decided that a prisoner ought to be seen by a nurse.

[154] There is a separate custody database onto which the nurses and doctors enter details about prisoners seen by them. If a Custody Sergeant had suspicions that a prisoner who had been brought to the charge bar and denied drug use was not being truthful, Dr Turowska said it would be breaching confidentiality for a nurse to give the Sergeant information regarding drug abuse which was on the custody database. However, in that situation, she would expect the nurse – or a doctor – to assess the prisoner in question. However, it was noteworthy that Dr Turowska thought that in this situation the Police would have information regarding past drug abuse on the Police computer database.

[155] In describing the system which obtained at the time of Kristoffer's death, Dr Turowska said that when she saw a person in custody who admitted drug abuse or was suffering from withdrawal, she would note this on the Admin 51 form. Indeed, she identified her notes and signature on an Admin 51 form dated 17 August 2006, which related to Kristoffer being seen by her on that date when he told her that he used cannabis and Valium and was suffering withdrawal symptoms. She explained that, under the new system, she would record these details – and details of any treatment or medication – on the custody database on the computer but would also still write a note on the Admin 51 form.

[156] Following Dr Turowska's examination of Kristoffer at the scene, his body was taken to the mortuary and on 30 November 2007, Professor Derrick John Pounder, Director of the Centre of Forensic and Legal Medicine in Dundee carried out a post – mortem examination, along with his colleague Dr Elizabeth Lin.

[157] Following the examination and certain other laboratory investigations, Professor Pounder and his colleague concluded that Kristoffer's death was due to the adverse effects of heroin and diazepam while in police custody. The common name for diazepam is Valium. The autopsy revealed no injuries or natural disease that could have caused or contributed to Kristoffer's death. In particular, there was no evidence of damage to the internal organs as a result of chronic drug abuse.

[158] Toxicology results indicated that Kristoffer had taken diazepam, prior to coming into custody, either during the late evening of 27 November or the early hours of 28 November 2007.

[159] The level of morphine (derived from heroin) was measured as 0.11 milligrams per litre of blood. When someone takes heroin, it is immediately broken down in the body, within minutes, to a compound commonly known as 6 / MAM. This is also relatively rapidly broken down, within a maximum of two hours, and is converted to morphine which was what was measured in this case. Professor Pounder explained that the level of morphine reported in heroin fatalities ranges from 0.01 to 3.0 milligrams per litre of blood, leading him to the conclusion that the level in Kristoffer's case was a potentially fatal level and that, if other causes of death could be excluded, it was reasonable to conclude that the heroin had caused death. The level of diazepam was not a toxic or lethal level and Professor Pounder explained that he had included it in the cause of death for the sake of completeness.

[160] In addition to the findings relating to heroin and diazepam, a trace of codeine was found in the blood and cocaine and cannabis in the urine, indicating the use of these drugs in the recent past. However, it should be noted that cannabis can be detected in the urine for several weeks after usage.

[161] Professor Pounder explained that it was not possible to give a precise length of time between the ingestion of heroin by Kristoffer and his death. However, in his expert opinion, Kristoffer must have survived at least twenty minutes after taking heroin and “probably more than an hour after taking the drug”.

[162] As far as the “process” of dying as the result of heroin is concerned, Professor Pounder said that he would expect the person to lose consciousness but that could be a gradual or rapid process. The person might be semi-conscious for a period of time, but rousable. Heroin depresses breathing and it is common for someone in this condition to be noted as snoring prior to death, which is frequently mistaken for sleeping comfortably. Even if an attempt is made to try to rouse the person at this stage he may respond with a grunt or a noise or a movement but he would not become fully alert.

[163] Professor Pounder was asked about the evidence of Bruce Rungay, paramedic, to the effect that Kristoffer’s body was still warm when the paramedics arrived in the cell and commenced resuscitation attempts. Again, Professor Pounder expressed reservations about how exact he could be, but said that as a general rule, if the body is still warm but the person otherwise appears dead, then the person has probably died within an hour or so. Various facts, such as the surrounding temperature can, however, have a bearing.

[164] Mr Boyle asked Professor Pounder about the use of the drug Narcan as an antidote to heroin and he described it as having an immediate and dramatic effect. He said that anyone who was trained to administer intravenous injections could administer it. It could only be effective, however, on someone whose heart was still beating, or where the medical assistance firstly succeeded in re-starting the heart.

[165] Professor Pounder also commented favourably on the availability, since January 2009, of nurses in the cell area. Nurses can of course administer intravenous injections and can therefore administer Narcan.

[166] Mr Boyle also canvassed with Professor Pounder the question of how regular checks on prisoners have to be in order to be effective. In the Professor's view, it was a difficult balance for the Police, but he accepted that half hour checks would increase the possibility that a change in the demeanour or manner in the person would be noticed.

[167] Professor Pounder graphically described the taking of heroin as a "chemical Russian roulette" and explained that there had been 45 deaths among heroin users in Tayside in 2008, the latest figures to hand, with 36 of these being due to the direct effects of injecting heroin. "Snorting" heroin is only marginally less dangerous than injecting.

The investigation by Fife Constabulary

[168] Following Kristoffer being declared dead, it was decided by the Deputy Chief Constable of Tayside Police that an outside Force should investigate the circumstances. Accordingly, Detective Chief Inspector Lee Dickson of Fife Constabulary was contacted and asked to conduct the investigation.

[169] DCI Dickson arrived at Tayside Police Headquarters on 28 November 2007 and was briefed by a senior CID officer. He also spoke with Mrs Batt, after which he decided that his team would consist of Fife officers only, including a Family Liaison Officer as Mrs Batt's point of contact. He also appointed his own Crime Scene Manager and Scenes of Crime Officer.

[170] He contacted the forensic pathologist who had attended earlier that day (after Dr Turowska had left) and established that from a preliminary visual examination, the pathologist had observed no evidence of injury or trauma to Kristoffer's body.

[171] DCI Dickson thereafter familiarised himself with the entire cell area and was shown the CCTV system. He noted that there were computer terminals in both the Custody Care Assistants' office and the Fingerprint Office but he gave no instruction regarding these; in particular he did not ask that the IT department investigate what transactions had been carried out on either computer during the previous night's shift.

[172] Various items were seized from Cell 11 and sent for forensic scientific examination. There were two pieces of tin foil, a crumpled piece of cling film and several pieces of torn cardboard found on the cell floor. The pieces of cardboard all appeared to have originated from the same item, namely a packet containing tissues. Such packets were supplied routinely to all cells. All the items were scientifically examined. One of the pieces of cardboard was rolled into a tube; such a tube can be used by a person "snorting" a powdered drug. Another piece of cardboard bore a brown residue which was found to contain Diamorphine (heroin). One of the pieces of tin foil contained a small amount of brown powder which weighed 0.011 grams and was found to contain Diamorphine (heroin).

[173] DNA was extracted from swabs taken from these pieces of cardboard and the DNA profile matched the DNA profile of the blood sample taken from Kristoffer.

[174] The tracksuit trousers worn by Kristoffer were seized and later searched by the Police, who found two pieces of cannabis resin weighing 13.07 grams in total.

[175] DCI Dickson instructed that all records relating to periods Kristoffer had spent in custody in Dundee Headquarters should be seized. Five officers thereafter analysed these and produced a synopsis which was the one referred to at the Inquiry.

[176] In addition, he instructed a review of all the CCTV footage for the relevant period. It became clear that the times shown on the CCTV cameras and therefore on the footage produced were inaccurate, to the extent of between 10 and 20 minutes.

[177] DCI Dickson explained that his responsibility was to carry out the investigation and then submit a report to the Procurator Fiscal. However, during the course of the investigation, there were identified certain problems which he considered should be drawn to the attention of Tayside Police management immediately, rather than await the conclusion of the investigation.

[178] He accordingly obtained permission from the Procurator Fiscal to alert Tayside Police to the fact that his investigation had established that all the audible buzzers in the male and female cells had been switched off. These should have worked in conjunction with the assistance lights but he and his team had been unable to establish when the buzzers had been switched off and on whose instructions. As a result of this alert to Tayside police management, the buzzer system was brought back into operation in December 2007.

[179] DCI Dickson's investigation team also established fairly quickly that the Custody Sergeant or other officer assessing a prisoner had no access to warning markers which were placed on the system during any previous custody episode because that warning marker did not transfer to the "nominal" page for that person, namely the page which would come up on the computer screen if any person came into custody and his basic details were put into the system. In addition, the Custody Sergeant or other officer did not have access to the paperwork – the Admin 51 forms - from any previous custody episode and was therefore totally reliant on the answers given by any prisoner to the set of questions on the Admin 51 form. This issue was

considered serious enough to have it drawn to the attention of Tayside Police management, prior to the conclusion of the investigation.

[180] In addition to those “system” issues, DCI Dickson identified the actions of “certain individuals” which he described as not to the standard the police would expect from their employees, and certainly not to the standards of the Prisoner Care Manual.

[181] When the investigation was concluded, DCI Dickson submitted a confidential Report to the Procurator Fiscal. Stuart Lewis was suspended from duty shortly thereafter, in April 2008.

The buzzer system

[182] As explained above, the Fife investigation team had quickly established that every toggle switch outside the cells – both male and female – in the cell area were in the “off” position. This meant that no buzzer sounded when a prisoner pressed the button inside his cell; all that happened was that the red assistance light was illuminated. The buzzers did, however, function in the juvenile detention rooms, situated on the floor above the cell area, where the switches were in the “on” position.

[183] What the team failed to establish was why this was the case and for how long it had been the case. The Fatal Accident Inquiry was no more successful: all that could be established was that they had been switched off “for years”. Of all the Custody Care Assistants who gave evidence, the only one who could remember the buzzers ever sounding was Linda Peddie, who had been in post for 18 years. She was, however, extremely vague about when they had stopped sounding. She thought that she had asked someone why, but that she had not received an answer.

[184] None of the three custody sergeants could remember the buzzers sounding: Sergeant Kidd (appointed in 2005) thought they were not working, as opposed to switched off; Sergeant Stewart, a custody sergeant since 2004, said it had never crossed his mind why audible alarms did not sound in the cell area, and if he had known that there could be audible alarms, he would have used them; Sergeant Loudon has also been a custody sergeant since 2004 and he knew that the buzzer switches were off, and had been told that the decision had been made some time ago, because of abuses of the system by prisoners. None of the sergeants knew who had made the decision but Sergeant Loudon said that he would have imagined that such a decision would have to be taken at management level, probably Chief Inspector level. He thought the light system worked “perfectly well”. All three sergeants, however, agreed that the reactivation of the buzzers had been an improvement.

[185] At senior management level, with responsibility for custody matters at the time of Kristoffer’s death, were Chief Inspector Lorna Robbie and Inspector Garry Brown. Both told the Inquiry that they had been unaware of the buzzers being switched off and had no idea when or why this had happened. When it was drawn to their attention by DCI Dickson, Inspector Brown immediately, by memorandum dated 19 December 2007, instructed that all buzzer switches be kept in the “on” position unless the prisoner in that cell was abusing the system, in which case a buzzer could be deactivated – for as short a period as necessary – and the reason recorded.

[186] Superintendent Hamish McPherson provided an interesting comparison to the system in the Dundee cell area, with its absence of any audible buzzers, and the system in Perth Police Office. Superintendent McPherson had been the Divisional Chief Inspector in Perth at the time of Kristoffer’s death and also at that time held the

chair of the Tayside Police Custody Users Group, one of the purposes of which was to share best practice. He also represented Tayside Police at the National Custody Forum which covers all eight Scottish Police Forces.

[187] Initially in his evidence, Superintendent McPherson seemed to suggest that a system of lights – with no audible buzzers – was probably sufficient in Dundee, contrasting it with Perth where there was no Custody Care Assistant permanently based within the cell area. In Perth, the responsibility for responding to calls for assistance was carried out by a member of staff in the Public Enquiry Office, and the system of lights and audible buzzers, which alerted that member of staff, was augmented by an intercom system, whereby the member of staff, duly alerted, could pick up the receiver and have a direct conversation with the prisoner.

[188] However, when it was put to Superintendent McPherson that in Dundee the assistance lights did not show “upstairs” where they could be seen by the custody sergeant (or by any other member of staff), he rather altered his view. He said that he had not realised that the light board was not replicated in the Public Enquiry Office.

[189] What Superintendent McPherson could not understand was how the decision to switch off all the audible buzzers had come to be made. He said that the Custody User Group would never have sanctioned it and that he could not see why any manager would make that decision; he did not know of anyone who could have supported that decision.

CCTV System

[190] As already referred to above, the Fife investigation team, when analysing the CCTV footage, found that all the cameras (apart from the one covering the Charge Bar) were set at the wrong time, due apparently to slippage. They were inaccurate to

the extent of anything between 10 and 20 minutes. This caused not only the investigators but also the Inquiry a great deal of difficulty.

[191] Despite the fact that the custody sergeants were supposed to review CCTV footage regularly, as was the audit department, nobody except Sergeant Stewart seemed to be either aware of or concerned about this problem. He regularly adjusted the timings, something he had taught himself to do, because, according to him, there was significant slippage in the space of a week. He had been on leave for two weeks prior to 28 November 2007.

[192] Neither Chief Inspector Robbie nor Inspector Brown was aware of the problem.

The Custody Sergeants

[193] As indicated, 3 custody sergeants gave evidence to the Inquiry, namely Sergeants Kidd, Stewart and Loudon. Sergeant George Loudon told the Inquiry about the qualities he considered were necessary for a custody sergeant. He said that knowledge, for example of legislation, procedural matters and first aid was essential, as was experience. In addition, a custody sergeant required an ability to carry out a fair assessment of a prisoner's care and welfare needs, bearing in mind that the person may be in crisis and leading a fairly chaotic lifestyle. As far as personal qualities were concerned, a custody sergeant needed to have a fairly even temperament, be patient and have an ability to communicate with the people he deals with.

[194] There was general agreement among the sergeants who gave evidence that the training provided to custody sergeants when they first took up post was inadequate: it consisted mainly of "shadowing" another sergeant and Sergeant Stewart in particular

had been obliged to replace someone at short notice, so had to rely on previous “shadowing” experience which he had carried out for the purposes of being a relief custody sergeant. However, all agreed that the training had improved and that it was due at the time of the Inquiry to improve further, with a two-day course designed for sergeants only (and not for all custody staff as previously).

[195] The sergeants also explained that levels of staffing had improved over the period since Kristoffer’s death: additional part-time Custody Care Assistants had been employed to assist with leave and at weekends.

[196] The duties of a custody sergeant were described by Sergeant Kidd: the job does not simply involve the assessment of prisoners and being in overall charge of the Public Enquiry Office and the Custody Suite (including the cell area). In addition, the sergeant is responsible for checking all the new custody reports which are completed during his shift. A custody report is prepared by the arresting police officer for transmission to the Procurator Fiscal as soon as possible after a person is detained in custody for the purposes of appearing in court the next lawful day. These reports must include all the information which the Procurator Fiscal requires in order to decide whether a person will be prosecuted and on what charges. Such reports are by definition detailed and often complicated. Another duty is the review of CCTV footage where there is a complaint by a prisoner.

Supervision

[197] One of the principal duties of the custody sergeant is, however, to supervise the staff under his command, including the Custody Care Assistants. CCTV footage was, according to the sergeants, checked regularly to see that the Custody Care Assistants were carrying out their duties as required. Sergeant Kidd also said that

when he went to the cell area during a shift, he would look at the cell sheets to see that the checks were being carried out within the correct parameters. The other sergeants also referred to checking cell sheets. However, Sergeant Stewart made it clear that the timing of checks, as shown on the cell sheets, were not checked against CCTV footage for accuracy.

[198] As Sergeant Kidd expressed it,

“You have to rely on those people to do the checks. I can’t be there every minute of the day; there has got to be some trust between myself and the staff to carry out the required duties. I don’t sit and watch them”.

[199] Further, in relation to response times, Sergeant Loudon emphasised that he was not looking at the CCTV monitors constantly. If he saw a light on, when he looked at the monitor, and then saw that it was still on 45 minutes later, he would do something about it, but at the end of the day the checking of the red lights and attending to the prisoners is a matter for the Custody Care Assistant “on the ground”.

[200] The sergeants were in general agreement regarding response times, namely that if an assistance light was illuminated by a highly vulnerable prisoner, the Custody Care Assistant should respond immediately, and if it was a low vulnerability prisoner, the response should be timeous and as soon as possible, perhaps up to a maximum of 15 minutes. All agreed that a response time of 49 minutes was totally unacceptable. According to Sergeant Kidd, on the night of 27/28 November 2007, the male Custody Care Assistant (Stuart Lewis) was “not overworked”, with 16 prisoners. On that basis, Sergeant Kidd would have expected him to answer an assistance light within 5 minutes.

[201] Two of the sergeants were asked about their views on the extent to which the male and female Custody Care Assistants should work as a team and about the responsibilities of each in relation to the other Custody Care Assistants' prisoners.

[202] Sergeant Loudon said that if the female Custody Care Assistant was in the Custody Care Assistants' room and a "male" light came on, it was incumbent on her to try and locate her male colleague, but if she could not, then "at the extreme end" she should check to see if there was a problem. He considered that the male and female Custody Care Assistants employed at that time had a good working relationship.

[203] Sergeant Kidd's view was that the male would normally be exclusively working within the male area, but that "sometimes the female will help out with a check if she had hardly any prisoners". In addition, a female Custody Care Assistant may respond to a call for assistance, if the male Custody Care Assistant is not available, in which case she "may go along and just check to see everything is fine".

The responsibilities of Senior Management

[204] While the day-to-day management of the Custody Suite and the Public Enquiry Office was, and is, the responsibility of the custody sergeants, there was only one custody inspector at the time of Kristoffer's death, namely Garry Brown, and above him was Chief Inspector Lorna Robbie, who was responsible for custody matters along with various other remits, such as property, productions, events, training and attendance management. She represented Central Division (Dundee) on the Custody Users Group. She had only been in post since July 2007 and moved on in August 2008. This was not untypical: the frequency of personnel changes in the senior management of custody matters was commented on by several witnesses.

[205] Both officers gave evidence. As already indicated, neither officer was aware of when or why the buzzer system had been deactivated; Chief Inspector Robbie said that she had been “surprised and disappointed” when she found out. She could not understand why it had happened, but accepted that it must have been due to a decision made at senior level.

[206] Inspector Brown gave evidence that the buzzers had been working when he was a custody sergeant in 2003/2004. He then became Custody Inspector (Central) in December 2006 and at that time he “just took it that they were in operation as they had been” when he was previously there. When he had been in the Custody Care Assistants’ office at any time that a light was activated, he said that the activation was accompanied by a noise which he described as a “ping”. He said that he had not noticed a lack of a buzzing noise. He could not understand why all the buzzers had been deactivated. Inspector Brown did, however, wish to emphasise that the light/buzzer system was a call system, not an emergency system. Indeed, there was no emergency system.

[207] Inspector Brown accepted that the intercom system in Perth (and in Arbroath) was an improvement in that the prisoner could convey what, if anything, was wrong with him. However, the installation of such a system in Dundee would not only be expensive, but difficult due to the age and fabric of the building.

[208] In any event, on 19 December 2007, Inspector Brown issued the instruction previously described, that every buzzer should be activated unless there was a legitimate reason for deactivating it, in which case the deactivation should be recorded on the appropriate cell sheet.

[209] As far as the problem with the CCTV system was concerned, namely that the timings on all the cameras in the cell area were significantly inaccurate, Chief

Inspector Robbie explained that there had been no system in place for checking this and that she had not known about the problem until after she left Central Division.

[210] As far as Inspector Brown was concerned, he unfortunately had a tendency to answer questions in paragraphs rather than sentences, but he was eventually pinned down by me into accepting that keeping the CCTV timings accurate would at least be an indication of professionalism. Up until that point, he had argued that it was not really that important, in the way that it would be for the City Centre cameras.

[211] The fact that Stuart Lewis had spent substantial periods accessing the Internet on the computer in the Fingerprint Office during the night of 28 November 2007 was not known to the Inquiry when these senior officers gave evidence; accordingly their attitudes to this are unknown. However, both were asked if, in their view, there should be another computer in the Custody Care Assistants' room and/or an extension of the light system to the Fingerprint Office (and perhaps the kitchen). This was on the basis that the excuse put forward by Stuart Lewis when he first gave evidence, for using the computer in the Fingerprint Office, was that Linda Peddie was using the computer in the Custody Care Assistants' room.

[212] Chief Inspector Robbie initially said that she understood that the computer in the Fingerprint Office was simply linked to the fingerprint system and was not a Force-linked setup. She then changed her mind and said she was not sure. In any event, rather than either of the above solutions to a Custody Care Assistant spending time unable to see the assistance lights, her proposed solution would be to remove the e-mail and intranet facility from the computer in the Fingerprint Office and make it a photographing and fingerprinting facility only. However, she also said that she thought there was "nothing to lose" by replicating the assistance light board at the Charge Bar. As far as Inspector Brown was concerned, he did not see why two

computers should be required in any event, given the nature of the Custody Care Assistants' job.

[213] In the course of his evidence, Inspector Brown was asked why it had not been checked as to what Stuart Lewis was doing on the computer on the night in question. His reply was that he did not know whether such a check had been asked for in the form of an IT Audit check. The reason he then gave was that this would be part of the independent investigation so "you do not ask for a second one from Professional Standards". Fortunately, as it turned out, Professional Standards were able to do just that during the course of the Inquiry, thereby providing invaluable evidence, which should have been obtained right at the start of the investigation.

[214] The Inquiry had been told that one of the purposes of the Custody Users Group was to share best practice and to consider any recommendations from whatever source. I therefore specifically asked Chief Inspector Robbie about the implementation of the recommendations contained in the Sheriff's Determination in the Fatal Accident Inquiry into the death of a prisoner in Perth Police Office on 24 December 2005. This Determination had been issued on 6 July 2007, just when Chief Inspector Robbie took up her post. She admitted that she had not read it, but assumed that everything which was required to be attended to had been so. Unfortunately, this was not the case: for example, a finding that the statement in the Tayside Admin 51 form, to the effect that a verbal response must be obtained when checking any prisoner, was inaccurate and inconsistent with the Prisoner Care Manual had not been acted upon by the time Chief Inspector Robbie left her post. Indeed, it had still not been corrected by the time that this Inquiry was held.

[215] Both Inspector Brown and Chief Inspector Robbie seemed to believe that the female Custody Care Assistant and male Custody Care Assistant who worked

together during a shift did so as a team. Both accepted that there were no written instructions regarding this but seemed to be of the view that there was no need; each would help out the other. Indeed, Inspector Brown maintained, “Yes, they work as a team. I know they do”.

[216] There was no job description for a Custody Care Assistant produced to the Inquiry, the only reference at all in the Tayside Police Prisoner Care Manual was under the heading “Female Prisoners” where it was stated that no male was to enter a cell occupied by a female prisoner unless a female accompanied him and that the foregoing instruction was also to apply to female officers and support staff when dealing with a male prisoner. Chief Inspector Robbie was questioned regarding the alleged “understanding” between Custody Care Assistants. She accepted that unlike in, for example, the Armed Forces, there were no “guard rules” detailing exactly what the responsibilities of individual Custody Care Assistants were, or what was required of such a Custody Care Assistant in terms of assisting his or her colleagues. She said that she “would expect them to work together to cover all the demands within that period. That includes visiting prisoners and responding to calls, for potential risk”.

[217] She said that dealing with female custodies was “almost exclusively” a job for the female Custody Care Assistant. She would not expect a male Custody Care Assistant to enter a female cell except in an emergency and for a male Custody Care Assistant to respond to a “female” light would be unusual. However, according to Chief Inspector Robbie, a female Custody Care Assistant could do so with a “male” light without entering the male cell in question and her understanding was that female Custody Care Assistants regularly responded to such lights.

[218] It had been clear from the evidence of both Stuart Lewis and Linda Peddie that there had been little if any communication between them during the shift of

27/28 November 2007. In particular, Stuart Lewis had not advised his female colleague when he had left the cell area to release prisoners. He said that he had assumed she would have heard him going. In turn, Mrs Peddie said that Mr Lewis did not always tell her where he was going and the import of her evidence was that at no time during the shift had she been aware of the whereabouts of Stuart Lewis.

[219] This was in complete contrast to what Chief Inspector Robbie said that she would have expected, namely that if one of the Custody Care Assistants was called away, for example to release a prisoner, it was reasonable to communicate with the other in order to work together as a team. She was asked if she would be surprised if that had not happened and she said that she would be very surprised. She went on to say that it was probably a basic requirement, when persons worked in close proximity to each other, to use their common sense and to communicate with each other. She said that she did not think it was an unreasonable expectation.

[220] In terms of actual supervision of the custody sergeants and the Custody Suite, it was not clear from the evidence of Chief Inspector Robbie exactly what that entailed as far as she was concerned. However, in terms of the hierarchy, it may be that her only direct supervisory role was in relation to Inspector Brown. Certainly, in connection with the question of audible buzzers, she said that she had only been in the Custody Care Assistants' room on one occasion when the assistance light had been activated, which suggested that she did not visit the cell area very frequently.

[221] As far as Inspector Brown was concerned, he expected his sergeants to check the Admin 51 set of forms to ensure proper compliance with them and he asked his sergeants to look at the CCTV footage with regard to those prisoners being booked in. He also asked them to "dip sample" police information reports; he said that he would "occasionally" himself go and look at the CCTV footage and the Admin 51

forms, just to ensure that they were being correctly filled out. He said that it was a rule that a sergeant should not “audit” any forms from his own shift.

The availability of the prisoner’s previous history

[222] A great deal of the Inquiry’s time was focussed – quite properly – on the fact that vital information was not available to a custody sergeant when he was making his assessment of a prisoner in relation to that prisoner’s vulnerability and deciding as to whether he should be strip-searched.

[223] No definitive explanation was ever provided to the Inquiry and there were contradictory views as to the availability of a facility to place a risk marker on a person’s nominal page, in the Integrity system, where that marker did not relate either to a pending criminal case or to a previous conviction (in which case SCRO and PNC checks should show all case-associated risk markers).

[224] However, Chief Inspector Robbie told the Inquiry that she was aware of the issue in relation to the Integrity database, prior to Kristoffer’s death, namely that information in relation to an individual custody episode, for example that the prisoner had a drug habit, would not be transferred automatically to that person’s “nominal page” on the system and would not therefore be available to the relevant staff at the time of any subsequent custody episode. She had thought, however, that nothing could be done to correct the problem as it was inherent in the move to the Scottish Intelligence Database (SID) and to the fact that the new system did not allow local variations to the same extent as previously.

[225] As was perhaps more clearly explained by Superintendent McPherson, the Integrity system was truly a corporate database and was also the Intelligence database for Tayside Police until SID was introduced. At that time, the Integrity system lost

the intelligence function and intelligence markers could no longer be placed on the nominal page by anyone other than a “specialist user”.

[226] The Inquiry heard evidence from two members of Tayside Police who were responsible for training custody personnel. They maintained that the training included instruction on how to refer such a request – for a marker to be placed on the nominal page – to the appropriate specialist user.

[227] However, there was no information regarding this in the Prisoner Care Manual and the only specialist user called to give evidence, Constable Martin Pattie, explained that he was one of four intelligence officers authorised to add markers to the various systems, but that neither he nor his colleagues had ever been asked to do so in relation to the Integrity system. He also said it would not be his job to put on a permanent marker if a custody sergeant asked him to do so; however, it was not divulged whose job it would be.

[228] Sergeant Stewart had given evidence that he had tried to have such a marker placed on the system but that his request had been turned down. When this was put to Superintendent McPherson, he said that he was disappointed that this had never been drawn to the attention of the Custody Users Group.

[229] What the sergeants had done, in order to ensure that some prior intelligence was retained and available at the assessment stage, was to photocopy the Form 19 relating to each prisoner, which is the “At Risk” form, and retain this in a lever-arch file. As soon as a prisoner arrived at the Charge Bar, the lever-arch file was accessed, and if there was a previous form, this could be checked. If not, the Form 19 for the current custody episode would be photocopied and inserted in the lever-arch file, if there was the information regarding a particular risk such as drug addiction. If the

current form contained additional or different information from that already held in the lever-arch file system, the existing form would be replaced with the new one.

[230] However, Sergeant Stewart explained that they had been instructed to abandon this practice by a “Data Protection person”, who was never identified during the Inquiry, despite the best efforts of Mr Reid, Solicitor for Tayside Police.

[231] The person from whom the Inquiry did hear in this regard was the extremely helpful Chief Inspector Donald Thomson, who oversees, on behalf of the Association of Chief Police Officers (Scotland), commonly known as ACPO(S), the interaction between the Data Protection Act and the Freedom of Information Act. He has had various senior responsibilities in relation to data protection, dating back to 2001.

[232] As he explained, the Data Protection Act is the framework within which any organisation must operate if it is going to process personal data. The information held should be accurate, relevant and up-to-date and should be sufficient for the purpose for which it is retained. The Act is concerned with reasonableness and proportionality.

[233] Chief Inspector Thomson saw no reason why the practice in relation to Admin 19 forms should have been abandoned. As he pointed out, persons coming into custody are in a vulnerable state and the police must try as best they can to realise their duty of care towards such people as extensively as possible. The retention of information from a previous custody episode would obviously inform the decision-making of a custody sergeant on the next occasion.

[234] In his view, it was more straightforward to file the paperwork numerically but obviously that did not make it easier to access and it was a question of striking a balance. As far as he was concerned, the Data Protection Act was concerned with the

information retained, and not the format in which it was kept. In his view, however, it was always better if the information was stored electronically.

Developments since 28 November 2007

[235] The senior officer chairing the Custody User Group at the time of the Inquiry was Detective Superintendent Roderick Ross. Since he took up post in April 2008, one of his responsibilities had been custody matters, within the wider portfolio of criminal justice.

[236] As he explained, the Custody User Group was responsible for guidance, policy, IT provision and training in relation to custody matters. All significant incidents must be reported to the Group, with the object of learning lessons and deciding whether changes are necessary. The Group meets approximately every 2 months and is responsible for managing a whole range of recommendations from different sources.

[237] The chair of the Custody User Group in Tayside also represents Tayside Police on the National Custody Forum. This Forum produced a National Custody Manual which came into force in May 2009. This is the first time there has been a National Manual and it has superseded the Tayside Prisoner Care Manual. However, the National Manual allows for local arrangements in relation to particular practices, for example strip-searching. Some practices are dictated by the actual layout of the building in which prisoners are processed and held. For example, the National Manual suggests that all custody suites and charge bar facilities should be on the same level, but that is currently not possible in Dundee.

[238] The new Manual was produced to the Inquiry and Detective Superintendent Ross was asked to expand on various sections. There is a section on Risk

Assessment & Management which is explained as meaning the assessment of the risk or potential risk that each custody may present to themselves, staff, other custodies and to others coming into the Custody Suite. It is stressed in the Manual that the assessment must be ongoing.

[239] In particular, it is stressed that information is a key element in successfully managing risk and that this can be obtained from the prisoner himself, the prisoner's friends and relatives, witnesses, all staff involved in the person's arrest or detention, the PNC and local IT systems, the CHS, healthcare professionals, other custodies and other relevant bodies and organisations. It is specifically stated that the risk assessment remains the responsibility of the custody officer (in Dundee, the custody sergeant) but that this can be completed in consultation with a healthcare professional.

[240] Superintendent Ross confirmed yet again that PNC and CHS markers or warnings relate only to previous convictions or to pending cases and that a marker regarding drugs on an individual custody record would still not transfer on to the nominal page of the updated Integrity system, now known as UNIFI. However, by this time, the solicitors and I had been given a demonstration at Police Headquarters of an upgrade to the UNIFI system which would make this possible in future and Detective Superintendent Ross was able to confirm that once this upgrade had passed the testing phase, it would be introduced throughout the Force.

[241] Detective Superintendent Ross was asked if the Custody Users Group had considered the question of access to previous Admin 51 forms, which were stored for three months within the Custody Suite/Public Enquiry Office. He was aware that these were filed for that length of time and were also filed numerically, rather than alphabetically. He agreed with me that young offenders tended to be in custody with

some regularity and that over a 3-month period, a young offender was very likely to have more than one custody episode; however, the information contained in these Admin 51 forms, stored a few yards away, was not made available to the Custody Sergeant assessing a prisoner for risk or vulnerability.

[242] Detective Superintendent Ross was asked to comment on the part of the National Custody Manual which related to the mental and physical condition of the custody, with particular relation to drugs. Under that heading in the Manual, it is stated that “consideration should be given to having all custodies who are believed to be under the influence of drugs seen by a healthcare professional as a matter of course”. Detective Superintendent Ross explained the arrangement with NHS Tayside, since January 2009, whereby nursing staff have a facility within the cell area and a computer linked to NHS Tayside, with access to all NHS records, including GP records. According to Detective Superintendent Ross, Tayside Police are seeing real benefits, one of the principal ones being that the prisoners tend to be much more candid with nurses than they would normally be with a custody sergeant or member of Tayside Police staff. A nurse can also challenge information given by a prisoner regarding medication he is taking, by checking his medical records.

[243] However, he emphasised that it was only if a prisoner was referred by the Custody Sergeant or if a prisoner asked to see a nurse and this was sanctioned by the sergeant, that the nurse would examine him. Detective Superintendent Ross was unaware of the proportion of prisoners seeing a member of nursing staff but said that it was a significant number. He explained that this was a 3-year pilot scheme which was funded jointly by Tayside Police and NHS Scotland.

[244] Another part of the Manual which was referred to specifically by Detective Superintendent Ross was the section dealing with the management and supervision of

the Custody Suite and the staff working in it; the person responsible in Tayside Police is the Custody Sergeant. The number of checks which the Custody Sergeant must complete when he comes on duty are outlined in the manual and Detective Superintendent Ross explained that there was now a handover document which ensured that this was the case.

[245] Due to the introduction of the new National Custody Manual, a new training programme had been introduced and was about to be implemented at the time of the Inquiry. The training programme had been divided into two modules, one of which was aimed specifically at Custody Care Assistants and the other at sergeants and police officers. The idea of the modules was that they were much more concentrated on training people on what they needed to know because there had been some criticism of previous training to the effect that it was somewhat unfocussed.

[246] One of the aspects of the Manual in respect of which there will be training is the question of observation of a prisoner. One change from the situation in November 2007 would be in relation to the categories of observation. At that time these were, as previously described, two main categories, namely a category of general observation for low vulnerability prisoners, involving checks at least every hour, and a category of frequent observation for high vulnerability prisoners, which would be at least every half-hour. In addition there was a category of constant observation. In the new Manual, there is a category of “intermittent observation” for those suspected of being intoxicated through drink, drugs, inhalants or having swallowed drugs, or whose level of consciousness was causing concern. This level of observation requires that the custody is visited and roused at least every 30 minutes, that he is positively engaged at frequent and irregular intervals, that his behaviour/condition is evaluated during observations and recorded in the custody

record and that any change in his behaviour or condition is reported to the custody sergeant immediately.

[247] As far as the relationship between and among Custody Care Assistants was concerned, Detective Superintendent Ross admitted that he was not particularly knowledgeable about the detail but seemed to assume that a male and a female Custody Care Assistant, working together on a shift, would work as a team. He did not know if there was any direct instruction on that aspect, but said that he would have expected that it was what he described as “a normal arrangement” and that somebody like the supervisor could deal with it. He seemed surprised when told that more than one witness in the course of the Inquiry had indicated that there was not necessarily an obligation on a male Custody Care Assistant to help a female or vice versa. He could see no good reason for that to be the case and said that he would expect a female Custody Care Assistant to keep an eye on lights if her male colleague was tied up with fingerprinting.

[248] Detective Superintendent Ross was asked about the section on rousing prisoners, to be carried out on the basis of a frequency determined by the Care Plan for that prisoner. Detective Superintendent Ross said that it could be somewhat intrusive if done every half-hour and that there really had to be very good cause for doing so. He said that in relation to one-hour checks, the member of staff would not normally rouse the prisoner.

[249] The National Custody Manual deals specifically with audit and inspection regimes which, it is stated, should be implemented for custody records and would include checking the legibility, accuracy and appropriateness of entries. In addition, checks should be carried out to ensure that all entries are timed and dated and that there was compliance with risk management measures. Also to be audited are the

quality of risk assessments and the quality and frequency of rousing visits to intoxicated custodies. Detective Superintendent Ross said that Tayside Police had a dedicated police inspector whose role is audit strategy and who conducts twice-yearly visits to custody suites to check all the matters contained within the National Custody Manual. However, he stressed that there was also a responsibility on individual police divisions to carry out their own audits and checks. For example, custody sergeants would be expected to have a system for checking the paperwork, namely the Admin 51 forms, prior to the prisoner being released or sent to court.

[250] As far as the fabric of the building was concerned and the actual equipment within the Custody Suite, there was firstly a Health & Safety Officer whose job it was to ensure that no issue arose in relation to safety within the cells, such as there being a potential ligature point. In addition, Detective Superintendent Ross assured the Inquiry that the CCTV equipment had now been updated and the problem regarding slippage had been resolved.

[251] In relation to the new National Custody Manual, I expressed my surprise to Detective Superintendent Ross that there was no mention of any difference between a person who surrendered himself voluntarily and a person who was brought in having been arrested or detained by police officers. I explained that my concern was that, as in Kristoffer's case, a person who surrendered himself had, by definition, ample opportunity to conceal drugs about his person. Mr Ross said that it was not something that the Custody Users Group or indeed the National Custody Forum had considered, but that it may be helpful to do so. He said that there was no question of routinely strip-searching people because it is so intrusive and as he described it "quite degrading". He also said that such a search would not necessarily reveal that drugs or other items had been hidden, particularly if they had been internally concealed.

[252] Detective Superintendent Ross spoke about a piece of equipment which had originated in America and which was a “cavity search scanner”, in the form of a chair on which the prisoner sat and which, by scanning, would tell whether any metal object had been concealed, such as a weapon or a phone. However, it did not appear to be successful in detecting drugs. Nevertheless, this kind of technological advance was obviously something which the National Custody Forum was anxious to monitor. Similarly, the National Custody Forum had looked at the question of placing sensors in cells, whereby an alarm would be set off if the occupant of the cell stopped breathing, but apparently these devices had proved to be largely unreliable.

[253] The other matter which was put to Mr Ross was the fact that there was no extension of the light or buzzer system to either the Fingerprint Office or the kitchen in the cell area, or of the light system to the Charge Bar. I did explain to him that at that stage I was minded to find that a reasonable precaution whereby Kristoffer’s death might have been avoided was for the Sergeants to have had a way of supervising the Assistants’ light system and of ensuring that calls for assistance were being attended to. Mr Ross said that he did not consider my view was in any way unreasonable and that Tayside Police would welcome any such finding. Indeed, Mr Ross went further and said that he thought the staff would welcome an intercom system but he did not know whether, in terms of the fabric of the building, that would be possible.

[254] Detective Superintendent Ross was the last witness to give evidence to the Inquiry and the matter was thereafter adjourned for Submissions at a later date.

SUBMISSIONS

[255] The various representatives lodged their written Submissions in advance of the adjourned Hearing and I am grateful to all of them for the obvious care and attention they paid to these Submissions. In the circumstances, I have included all the Submissions, in full, at Appendix 3. However, it is only appropriate that I refer to them in some detail in the body of this Determination.

[256] The parties addressed the various sub-sections of the Section 6 (1) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 which provides that 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;
- b) the cause or causes of such death or any accident resulting in the death;
- c) the reasonable precautions, if any, whereby the death or any accident resulting in the death might have been avoided;
- d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- e) any other facts which are relevant to the circumstances of the death.

[257] In relation to Section 6 (1) (a), regarding where and when the death occurred, there was no disagreement about where Kristoffer had died, and with the exception of Mr Boyle, who represented the Batt family, it was agreed that Kristoffer must have died between 0706 and 0746 hours on 28 November 2007. Mr Boyle submitted that the finding could only be to the effect that Kristoffer died between 0510 and 0706 because it was not possible, standing the evidence, to be more precise and because no reliance could be placed on the alleged visit by Stuart Lewis at approximately 0601 hours, given the unreliability of any evidence given by Stuart Lewis.

[258] In relation to Section 6 (1) (b), namely the question of the cause of Kristoffer's death, there was no disagreement that it had been caused by the adverse effects of heroin, and that Professor Pounder had included Diazepam, as a factor, for the sake of completeness.

[259] However, in relation to the remaining subsections of Section 6 (1), there was a great deal of divergence of views in terms of the Submissions and it would be only fitting to set these out in some detail.

Section 6 (1) (c)

[260] Mr Robertson submitted on behalf of the Crown that the only reasonable precaution whereby the death might have been avoided was the provision of a system of information retention, whereby information obtained and relating to drug abuse by Kristoffer Batt in the course of any custody episode in which he was involved, was available to the person assessing his vulnerability at the commencement of any subsequent custody episode.

[261] Mr Boyle, solicitor for the Batt family, submitted that there were several precautions which could be described as reasonable and were precautions whereby the death of Kristoffer might have been avoided. In particular, he submitted that Kristoffer's death might have been avoided if there had been a proper system devised for the care and custody of prisoners at Tayside Police Headquarters and if that system had been complied with and properly supervised. He specifically referred to the two Custody Care Assistants on duty that night, namely Stuart Lewis and Linda Peddie, and submitted that if they had carried out the duties entrusted to them, this would have been a reasonable precaution whereby Kristoffer's death might have been avoided. Similarly, he submitted that an effective system of supervision of the

Custody Care Assistants would have been a reasonable precaution. Finally, he submitted that a medical regime, whereby Narcan, the opiate antidote drug, could be administered to any prisoner found to be suffering the effects of an opiate was also a reasonable precaution.

[262] Perhaps unsurprisingly, Miss Nunn on behalf of Stuart Lewis submitted that there were no reasonable precautions that Mr Lewis could have or should have taken which might have avoided Mr Batt's death. She did not address the question of whether there were any such reasonable precautions in relation to any other person or procedure.

[263] Mr Reid, Solicitor for Tayside Police, provided very helpful Submissions regarding the evidence in general, as will be seen at Appendix 3, but did not specifically seek to suggest that any Finding should be made in terms of either this sub-section, or indeed in terms of sub-sections (d) and (e).

Section 6 (1) (d)

[264] Only Mr Boyle, for the Batt family submitted that I should make any Finding that there were any defects in the system of working which contributed to the death of Kristoffer Batt. As he said, there was some overlap between the factors which he submitted should be taken into account under this heading and those which were relevant to Section 6 (1) (c), and the question of reasonable precautions. Mr Boyle submitted that the set of forms, which has been referred to in this Determination as the Admin 51 set of forms, required sensible amendment, coherently planned. The purpose would be to enable special difficulties to be presented in more detail, giving warning to the officers assessing the vulnerability of prisoners. In addition, Mr Boyle submitted that there was a lack of historical information available to those officers, as

a result of a lack of accessibility to previous records. In Mr Boyle's submission, there had been a failure to devise, maintain and verify a standard admission procedure for these custody officers.

[265] Mr Boyle further submitted that there had been a failure to appreciate the difference between persons surrendering to custody and persons who have been arrested; as he pointed out, the latter have had no time "to plan for the secretion of drugs".

[266] Mr Boyle also submitted that the Custody Care Assistants had failed to perform their prescribed duties and that there was clearly a culture whereby civilian staff could do what they like, with impunity, "whether it be going to Tesco for shopping, read books or surf the internet".

[267] Mr Boyle also submitted that there were defects in the system of working, namely the failure to maintain and check the alarm systems and the CCTV cameras, which should be taken into account under this subsection.

[268] Further, according to Mr Boyle, the lack of supervision and monitoring by senior officers of the CCTV system and the lack of accountability as far as the senior officers were concerned were defects in the system of working which contributed to the death of Kristoffer Batt.

Section 6 (1) (e)

[269] Perhaps unsurprisingly, given the extensive and detailed evidence regarding the system for the care and control of prisoners in Tayside Police Headquarters, all parties submitted that there were several facts which were relevant to the circumstances of Kristoffer Batt's death.

[270] Mr Robertson, for the Crown, submitted that the deactivation of the system of buzzers within the cell area had removed a possible additional safeguard for persons in custody. Further, he submitted that there was a training need for Custody Care Assistants to enable them to understand better the necessity to communicate with one another in relation to their responsibilities.

[271] Mr Boyle had obviously concentrated, in his Submissions, on Subsections 6 (1) (c) and (d) and accordingly, the only Submission he made in relation to Subsection 6 (1) (e) was the fact that “Every time there is a death in custody, Police Officers turn up and give evidence highlighting the defects, advising what steps are in hand to deal with this matter usually after discussion with other Police Forces and they are never implemented by the time of the next Fatal Accident Inquiry”.

[272] Miss Nunn, on behalf of Stuart Lewis, submitted that in terms of the facts relevant to the circumstances of Kristoffer Batt’s death, there were three particular failures by Stuart Lewis, firstly his failure to deactivate Kristoffer Batt’s cell light on attending his cell at 0601 hours, secondly his failure to notice that the light remained activated when he left the building at 0650 hours and thirdly his failure to communicate with Linda Peddie, his female colleague, that he was unsighted as far as the cell lights were concerned, for large periods of time during his shift.

[273] Mr Reid, for Tayside Police, did not seek any particular Finding regarding this subsection, although, as previously indicated, he helpfully summarised all those facts which he considered to be relevant to the circumstances of Kristoffer Batt’s death. He quite properly drew attention to the fact that Kristoffer Batt was a drug abuser and that he had consumed the drugs responsible for his death. As he submitted, Kristoffer Batt had decided to abuse his body through taking such substances and this effectively resulted in him killing himself. He had decided to take the drugs in

advance of being taken into custody and had deliberately concealed the drugs on his person when taken into custody.

THE DETERMINATION

[274] The Determination required of a sheriff in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is a Determination setting out “the following circumstances of the death so far as they have been established to his satisfaction –

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death.”

[275] The purpose of a Fatal Accident Inquiry is to enlighten and inform those persons who have an interest in the circumstances of the death, most importantly members of the deceased’s family. However, it is also to ensure, if mistakes were made and there are lessons to be learned, that these are identified and drawn to the attention of those responsible for preventing a recurrence.

[276] It is not the purpose of a Fatal Accident Inquiry to determine any questions of criminal or civil liability or to apportion blame between or among any persons involved in the death. As has been said many times, it is a fact-finding procedure, not

a fault-finding procedure. Nevertheless, evidence may be led which tends to demonstrate that there was fault on the part of a person or persons and a sheriff is not precluded from reaching findings which may imply fault where it is proper to do so.

As was said by IHB Carmichael in *Sudden Deaths and Fatal Accident Inquiries*, Third Edition, at paragraph 5-63,

“If the evidence led before in the inquiry is sufficiently strong, then findings made under 6(1)(c) and (d) may well point fairly strongly to the existence of at least fault and negligence”

and at paragraph 5-76

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

[277] In 2009, Lord Cullen carried out a Review of the system of Fatal Accident Inquiries and recognised this very fact. He concluded in his Report that the investigation into the circumstances of a death in the context of a Fatal Accident Inquiry may disclose grounds for criticism from which a basis for alleging fault may be inferred. He said that this may be unavoidable if the Fatal Accident Inquiry is to fulfil its function of investigating the circumstances of the death.

Section 6(1)(a)

[278] I **determined** that Kristoffer died in cell 11 at Police Headquarters, Dundee between 07.06 hours and 07.46 hours on 28 November 2007. The only submission to

a different effect was that made by Mr Boyle, which suggested that I could not rely on the evidence of Stuart Lewis that Kristoffer was alive at 06.01 or that of Alastair Smith, who spoke to Kristoffer having turned over and “grunted” at 07.06. I agree with Mr Boyle that it was difficult to accept any evidence given by Stuart Lewis as being credible, given the fact that the overwhelming majority of his evidence had been proven to be incredible, but in fact, I tend to accept his evidence in respect of his attendance at cell 11 at 06.01, for the simple reason that he had no reason to lie regarding this aspect of his evidence. However, I will return to that later. I also believed the evidence of Alastair Smith and it is in my view significant that it is consistent with the evidence of Bruce Rumgay, paramedic, who concluded, on the basis of his extensive experience, that Kristoffer had been dead for 10-15 minutes prior to the arrival of himself and his colleague at 07.46.

Section 6(1)(b)

[279] There was no dispute that Kristoffer Batt died as a result of the adverse effects of heroin whilst in police custody. Professor Pounder also included diazepam in the cause of death on the death certificate for, as he said, the sake of completeness. I have followed his approach and have so **determined**. I am satisfied that Kristoffer ingested the diazepam prior to surrendering himself at Police Headquarters, and that he snorted the heroin in cell 11, using torn up cardboard from a tissue box. In my view, he probably did so shortly before 06.00 hours.

Section 6(1)(c)

[280] I have made several findings in respect of this subsection. The Court in a Fatal Accident Inquiry must consider in the wider public interest whether the death might

have been avoided by the taking of a precaution which it considers would have been reasonable in the circumstances at the time. As already stated, the aim is to help prevent a death in similar circumstances in the future. A Fatal Accident Inquiry has been judicially viewed as an exercise in applying the wisdom of hindsight. The subsection requires that such a precaution is a matter which must be established “to the satisfaction of the sheriff” and accordingly is a matter of evidence and reasonable inferences from the evidence, as opposed to speculation about remote or unlikely possibilities for which there is no evidential foundation.

[281] I have accordingly **determined**, firstly, that the carrying out of a full body search of Kristoffer Batt when he was placed in cell 11 at 04.20 hours or thereby on 28 November 2007 was a reasonable precaution whereby his death might have been avoided. A full body search, or “strip search” as it is generally known, is an embarrassing and undignified procedure, according to Sergeant Kidd (and others) who made the decision not to conduct such a search in Kristoffer’s case on 28 November 2007. If Kristoffer had previously been convicted of a drugs offence, he would automatically have been strip-searched although it was not clear whether having a drugs “marker” on either of the national police databases would have had the same result. Such a marker could, of course, be present where a person had not been convicted of a drugs offence but had such a case pending.

[282] It was stressed by more than one of the custody sergeants that a strip-search did not always reveal concealed items, particularly when something has been concealed internally, in the anus. However, in Kristoffer’s case, I am satisfied from the evidence of Sean Smart that Kristoffer had not concealed anything internally and that the heroin and cannabis resin which he took into the cell was in fact simply

wedged in the cleft of his buttocks. Accordingly, it is in my view more than likely that a strip-search would have resulted in these items being found.

[283] The reasons given by Sergeant Kidd for not carrying out a full body search were that Kristoffer did not automatically qualify, having no previous conviction or marker for drugs, and because he did not appear to Sergeant Kidd to be under the influence of any substance. What Sergeant Kidd did not know was that Kristoffer had admitted on previous occasions when he was in custody that he took drugs including heroin and the reason that Sergeant Kidd was unaware of this was because there was no system for retrieving information regarding previous custody episodes.

[284] The computer system at that time, called Integrity, had initially included an intelligence function, which allowed the addition and retention of intelligence on individuals over and above convictions and pending cases. However, this intelligence function had been lost when the Scottish Intelligence Database (SID) was brought in as a national system, which meant that a warning marker placed on an individual custody record would not transfer automatically to the principal or “nominal” page for the person concerned.

[285] The custody sergeants had attempted to get round this problem by retaining copies of the “risk” forms, also referred to as Admin 19 forms; they had retained these in a lever arch file which could readily be consulted by the officer responsible for assessing a prisoner. The Inquiry was told that this system had been discontinued, due to an unidentified data protection officer concluding that it was a breach of the data protection rules. In fact, Chief Inspector Donald Thomson, who has had various senior responsibilities in relation to data protection, dating back to 2001, told the Inquiry that he could not assist in identifying this person but could state categorically that he disagreed with the conclusion, namely that the retention of copies of the

Admin 19 forms would in some way breach the data protection legislation. His very sensible approach was that it was a question of striking a balance and although he was of the view that it was always better if information was stored electronically, he did not quibble with an approach that would allow paperwork to be accessed for the purposes of informing the assessment procedure.

[286] However, the retention of copies of the Admin 19 form would, unfortunately, not solve the problem as it became clear from those sets of forms which were produced to the Inquiry that information recorded elsewhere in the Form 51 or Form 51A was not necessarily replicated in or transferred to the risk form, namely the Admin 19. For example, the Admin 19 form for Kristoffer's custody episode dated 20 September 2007 only contained the words "SCRO markers" in the risk box, and there was no tick relating to "known drug/alcohol dependency". This was despite the fact that Sergeant Loudon has categorised Kristoffer on the Admin 51 form as being of high vulnerability and had noted that he took heroin, valium and methadone. He had been strip-searched on that occasion and the reason noted was because he had a heroin habit. There was also information contained in that set of forms that he had been seen by the police casualty surgeon because he was suffering from drug withdrawal and had admitted that he was a heroin addict with depression problems.

[287] All this information was sitting in the filing system near to the charge bar, where Sergeant Kidd carried out his assessment of Kristoffer. However, because all these forms were filed numerically, rather than alphabetically, it would have been time-consuming to retrieve this information. It was also suggested that it would be time-consuming to read such a form, even if it could be quickly retrieved. I find that difficult to accept: during the course of the Inquiry, a large number of these forms were produced, for both male and female prisoners who were in custody on the night

of 27/28 November 2007. I could certainly read them very quickly and I have no doubt that an experienced custody sergeant could do so far more quickly than I.

[288] I am conscious, however, of what was said by Chief Inspector Thomson, namely that it is always preferable if information can be stored electronically and accordingly it was with a great deal of interest that I and the solicitors at the Inquiry had a demonstration of a new facility which was being tested at the time of the Inquiry and which was, it was suggested, the answer to this particular problem. The result of new software on the computer system (which is now called UNIFI) was that a marker put on to an individual custody record will automatically appear thereafter in the nominal or principal screen. Certainly, the demonstration, for which I was grateful, showed a facility which would make a huge difference, as long as the appropriate information was placed in the individual custody record.

[289] Therein lies my worry: in my view, the only guaranteed way of ensuring that relevant information regarding previous custody episodes is available to the assessing officer is by extracting that information and passing it to the officer at the appropriate time. I consider that the Admin 51 set of forms should be filed alphabetically. They are already stored for three months before being filed elsewhere. This is a period outwith which information could be said to be no longer current or relevant and I am not suggesting that records outwith that period should be retrieved. In other words, the information is stored near the charge bar in any event, and it seemed to me ridiculous that it was not utilised. The minor inconvenience of having to rearrange it back into numerical order for the purposes of filing after the three month period is up, seems insignificant when compared with the value of that information.

[290] Accordingly, I have **determined** that the availability to the custody sergeant of information that Kristoffer Batt admitted on previous occasions when he was in

custody that he took drugs including heroin, was a reasonable precaution whereby his death might have been avoided.

[291] In evidence, Sergeant Kidd accepted that if he had been in possession of the information referred to above, he would have carried out a full body search.

However, he said that he would not have classified Kristoffer as being of high vulnerability, because in his view Kristoffer was not under the influence of any substance. He reached this conclusion following close observation of Kristoffer, during the assessment procedure and the standard search, which he himself carried out.

[292] I found this extremely difficult to understand. While I accept that more than half of persons coming into custody at Tayside Police Headquarters have a drug problem, and that, in effect, they cannot all be classed as highly vulnerable, I have grave concerns that a youth of 17, with the drug history which would have been available to Sergeant Kidd had the forms for the previous three months been retrieved, could be classed as anything other than highly vulnerable. It should be remembered that in addition there was already a marker known to Sergeant Kidd relating to Kristoffer having a mental health issue.

[293] The point of such classification is of course that he would have been subject to half-hourly checks. As Professor Pounder explained, if a person was subject to half-hour checks, it would increase the possibility that the person responsible for his care would notice a change in his manner or demeanour. In other words, in Kristoffer's case if he had been subject to proper half-hourly checks, the inevitable change in him between the point when he had not taken heroin in the cell and the point after which he had, would have been likely to have been noticed. Accordingly, I have **determined** that it would have been a reasonable precaution whereby Kristoffer's

death might have been avoided if he had been classed as of high vulnerability and subject to half-hourly checks.

[294] Apart from the system of checks, the frequency of which is determined by the custody sergeant or other assessing officer, there is of course a call system whereby a prisoner should be able to attract the attention of a Custody Care Assistant. It goes without saying that any such system should be designed to alert those responsible for the care of prisoners wherever they are in the cell area. For good reason, therefore, there would appear to have been installed many years ago in the cell area of Tayside Police Headquarters, a combined system of lights and buzzers. It therefore beggars belief that all of the buzzers were switched off some years ago, that no record was kept of the decision to do so and that at the time of this Inquiry, no explanation could be proffered for what had happened. It was, quite simply, disgraceful.

[295] In my view, if the buzzer system had been operating, there is an evidential basis for concluding that Kristoffer Batt might have been able to attract the attention of Linda Peddie, the female Custody Care Assistant, although it is unlikely that he would have been able to attract the attention of Stuart Lewis, the male Custody Care Assistant, when the latter was ensconced in the Fingerprint Office, surfing the Internet. I considered Mrs Peddie to be a reasonable and compassionate woman, who was horrified at what she realised had been a dereliction of duty on her part, in the sense that she had failed to notice the illumination of Kristoffer's assistance light. She herself said that the reactivation of the buzzer system had been an extremely helpful change.

[296] It is known that Kristoffer called for assistance on two occasions, that he was ignored by Stuart Lewis on the first occasion for 49 minutes, for over 15 minutes on the second, and that his assistance light was not switched off by Stuart Lewis when he

did finally attend on the second occasion. Without the buzzer system, there was nothing Kristoffer Batt could do to attract attention. I am satisfied that the operation of the combined buzzer and light system was a reasonable precaution whereby Kristoffer's death might have been avoided, and have so **determined**.

[297] Nevertheless, there was an assistance light system operational on the night of 27/28 November 2007 and it was the failure of Stuart Lewis, Custody Care Assistant, to fulfil his duties in connection with that system, which resulted in Kristoffer's requests for assistance being ignored for long periods. Stuart Lewis deliberately chose to position himself in the Fingerprint Office, for lengthy periods, where he could not see any assistance lights at all. He even failed to operate the system properly, when he finally did attend Kristoffer's cell at 06.01 hours, in that he failed to deactivate the assistance light.

[298] However, in my view, the most significant failure on the part of Stuart Lewis occurred at this stage, when he failed to engage with Kristoffer. He described looking into the cell and seeing Kristoffer sitting up on the bunk, awake, but with his head down, looking at his feet. Instead of asking Kristoffer why the light was illuminated and whether there was anything he required, Stuart Lewis did not say a word to Kristoffer. This was despite the fact that he admitted in evidence that he had found it strange that Kristoffer did not even look up when he must have been aware that there was someone at the cell hatch; he would have heard the footsteps and certainly would have heard the hatch being opened. Stuart Lewis could not explain in evidence, despite being pressed, why he had failed to engage with Kristoffer at that stage. However, it seems clear, given the computer expert's evidence, that Stuart Lewis was back, surfing the Internet, in the Fingerprint Office, within a few minutes, and the obvious explanation is that he was very reluctant to ask Kristoffer any

question, the answer to which might have prevented him from returning immediately to the Fingerprint Office.

[299] Kristoffer's behaviour was so unusual that it is in my view reasonable to draw the inference that he was under the influence of heroin, having recently ingested it. This would accord with Professor Pounder's evidence that Kristoffer had probably taken the heroin over an hour prior to his death, which on the basis that I accept the evidence of Bruce Rumgay, probably occurred around 07.30. Had Stuart Lewis performed his job properly, by speaking to Kristoffer at that time, and obtaining a response, there would seem to be little doubt that Kristoffer's demeanour might well have given rise to suspicion in the mind of an experienced Custody Care Assistant.

[300] Accordingly, I have **determined** that the fulfilment of his duties by Stuart Lewis in carrying out all of the above steps appropriately amounted to a reasonable precaution whereby the death of Kristoffer might have been avoided.

[301] However, it must be accepted that, however incompetent and negligent Stuart Lewis was, he was allowed to spend lengthy periods failing to respond to assistance lights because he was not being properly supervised. There was absolutely no system of supervision which ensured that Custody Care Assistants were answering requests for assistance within a reasonable time. Although I found it difficult to believe Stuart Lewis about any aspect of his evidence, if he is to be believed, then he and others were spending time on the Internet every shift, accessing sites which were nothing at all to do with their work. I certainly believed Linda Peddie when she said that it was of no real concern if she exceeded the time allowed for her "long break", namely 48 minutes, as she did on the night of Kristoffer's death, albeit only by a few minutes.

[302] The impression I gained was one of lax supervision. It was difficult to escape

the conclusion that the very qualities which Sergeant Loudon described as necessary for a custody sergeant, namely an even temperament, patience and an ability to communicate with the persons brought into custody, were not necessarily the personal qualities one would associate with a strict supervisor. However, although the custody sergeants are the frontline supervisors, there were, in the hierarchy, various tiers above them, and in particular the inspector and the chief inspector with responsibility for custody matters. It was of concern that neither Inspector Brown nor Chief Inspector Robbie seemed to have much idea about what actually went on in the cell area, as exemplified by the fact that they assumed the male and female Custody Care Assistants were working as a team, when that could not have been further from the truth in the case of Linda Peddie and Stuart Lewis. I have accordingly **determined** that proper supervision of the Custody Care Assistants was a reasonable precaution whereby the death of Kristoffer Batt might have been avoided.

Section 6(1)(d)

[303] This subsection entitles the Sheriff to determine that there was a defect in any system of working which contributed to the death. Unlike section 6(1)(c), here the Court must be satisfied, on the balance of probabilities, that there was a causal link between the defect and the death. In the case of a death in custody, it would be appropriate to make such a finding where any one of the procedures or the routines within the custody suite had contributed positively to the death. While I have identified deficiencies in the system, such as the failure to have relevant information from previous custody episodes available to the Custody Sergeant or other assessing officer, it would not be possible for me to hold there was a direct causal link between

any deficiency and the death of Kristoffer Batt. Accordingly I have made no findings in terms of this subsection.

Section 6(1)(e)

[304] The facts to which I have drawn attention under this subsection would, I hope, already be evident from the narration of the circumstances surrounding Kristoffer's death. What it is difficult to convey, however, is the actual physical set up in the cell area. I was indebted to Mr. Reid, Solicitor for Tayside Police, for arranging a court visit. I was able during the visit to stand in the kitchen and in the Fingerprint Office while the now functioning buzzers were activated. Even with the doors open and in complete silence, only occasionally could a faint buzzing noise be heard. It goes without saying that anyone in the kitchen or Fingerprint Office is not in a position to see any assistance light. In my view, the light and buzzer system should be extended to these areas, and I so **recommend**.

[305] Perhaps more importantly, however, I **recommend** that there be installed an extension of the assistance light system to the charge bar, in order that the Custody Sergeant on duty can readily see whether Custody Care Assistants are responding promptly to requests for assistance. When Detective Superintendent Roderick Ross, the Chair of the Custody Users Group in Tayside Police, gave evidence, I indicated that I was minded to find that a reasonable precaution whereby Kristoffer's death might have been avoided was for the Sergeants to have had a way of supervising the light system and of ensuring that calls for assistance were being attended as I had previously indicated, Mr. Ross said that he did not consider this view to be unreasonable and indeed that Tayside Police would welcome any such finding. I agree, however, with his assessment that it would be inappropriate to extend the

audible buzzer system to the charge bar as this would be an unwelcome distraction and unnecessarily intrusive.

[306] I was astonished to find that neither in the Prisoner Care Manual for Tayside Police which was in force at the time of Kristoffer's death nor in the new National Manual was there any reference to a distinction between those persons who hand themselves into custody, for example by surrendering to a warrant and those who are arrested by police officers and brought into custody. It would appear self evident that those who surrender themselves to custody have been in an ideal position to conceal drugs on their person and yet there is no instruction that a high index of suspicion should be applied to such persons, particular where there is a history of drug use. I **recommend** that this matter should be discussed at the National Custody Forum and the National Custody Manual amended, as deemed appropriate.

[307] The cell area of Tayside Police Headquarters is not a pleasant environment, and in my view must be intimidating to even the most hardened 17 year old. There are separate detention rooms for juvenile custodies, who are defined as being under the age of 16 (or over 16 and under the supervision of the Children's Panel). A juvenile is automatically classed as "highly vulnerable" and therefore subject to half hourly checks. The European Court of Human Rights classes a young person as a juvenile until the age of 18 years as do most EU States. In my view this is the correct, civilised approach. I am not suggesting that a youth of 17 should necessarily be placed in a juvenile detention room of which there are only a small number in Tayside Police Headquarters. What I **recommend** is that a classification of high vulnerability, leading to half hourly checks, is the proper, civilised approach, to a young person of 16 or 17.

[308] Finally, under this subsection, I have drawn attention to the fact that there do not appear to be any detailed job descriptions for either the male or female Custody Care Assistant post in Tayside Police. From the Custody Care Assistants themselves right up to Detective Superintendent Ross, through the Custody Sergeants, Inspector Brown and Chief Inspector Robbie, no two witnesses agreed as to the respective roles of the male and female Custody Care Assistants, something which I found quite shocking. It is difficult to see how a decision could be reached as to whether someone had neglected his duties when it could not be said with certainty what his duties were. I accordingly **recommend** that a detailed description of what is expected of Custody Care Assistants in terms of their individual and joint responsibilities is drawn up and reviewed on a regular basis.

CONCLUSIONS

[309] This was a lengthy and complex Inquiry which examined in detail the care afforded by Tayside Police Service to Kristoffer Batt on 28th November 2007. To that extent, it was a snapshot of the standard of prisoner care achieved by the Force, and it was not a flattering picture.

[310] However, the Inquiry was far more wide ranging than that implies: it examined all aspects of the admission procedure, including both the computer and the manual record systems relating to persons brought into custody. It considered the risk and vulnerability assessment procedures and the extent to which the assessing officer's decision regarding frequency of the checks was followed through. The Inquiry also looked at the arrangements for ensuring that prisoners' requests for assistance were answered and the extent to which mechanical and technological systems were employed in achieving this. In addition the available guidance and

training and the roles of all those personnel involved in the custody suite, from Custody Care Assistants to the Detective Superintendent, were examined.

[311] Further, through the good offices of Mr. Reid, Solicitor for Tayside Police, the Inquiry also performed a somewhat unusual, investigative role: it was only during the course of the Inquiry that, at his behest, an investigation by the Professional Standards Department of Tayside Police revealed what Stuart Lewis had actually been doing on the computer that night, while Kristoffer Batt's calls for assistance went unanswered, namely surfing the Internet.

[312] It is to the credit of Tayside Police that the Inquiry received co-operation at all levels, in responding to various issues which arose during the Inquiry. I have already referred to the demonstration of the new computer system (UNIFI) software and to the visit to the custody suite and cell area. In addition, whenever documentation was referred to by a witness and this has not been anticipated as being necessary prior to the Inquiry, this documentation was invariably located by the Police and produced to the Inquiry as a matter of urgency. The same applied to additional witnesses.

[313] The Inquiry revealed several deficiencies in both certain procedures and certain people employed by Tayside Police. However, it should be noted that there have been many improvements since the death of Kristoffer Batt. In particular, the introduction of nurses into the cell area, with access to the NHS database, can only assist in circumstances where the number of prisoners with drug problems is not likely to decrease in the future. Better training and guidance (in the form of the National Custody Manual) are also important steps forward, to say nothing of the most basic improvement, namely the reactivation of the buzzer system. However, it seems to me that there are further improvements to be made and I hope I have clearly set out what, in my view, still requires to be done.

[314] Mr. and Mrs Batt were present for the first part of the Inquiry and Mrs Batt attended thereafter. Understandably, she found it a harrowing experience but she remained a dignified presence throughout. I hope that the Inquiry provided answers to most if not all of the family's questions.