SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE

[2020] FAI 1

DUN-B140-19

DETERMINATION

BY

SHERIFF ALASTAIR CARMICHAEL

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

into the death of

MARK PATRICK HUTTON

Dundee, 6 December 2019

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:–

MARK PATRICK HUTTON, born 26 May 1986, resident in Dundee, died at 13:29 hours on 5 March 2016, at Cell 8, Tayside Police Divisional Headquarters, West Bell Street, Dundee DD1 9JU.

In terms of section 26(2)(b) no finding is necessary because there was no accident that led to Mr Hutton's death.

In terms of section 26(2)(c) the cause of Mr Hutton's death was 1(a) Acute and Chronic Adverse Effects of Methadone, Diazepam and Etizolam and Possible Inherited Cardiac Abnormality.

In terms of section 26(2)(d) no finding is necessary because there was no accident that led to Mr Hutton's death.

In terms of section 26(2)(e) that there are no precautions which could reasonably have been taken and, had they been taken, might realistically have avoided the death of Mr Hutton.

In terms of section 26(2)(f) that there were no defects in any system of work which contributed to the death of Mr Hutton.

Recommendations

In terms of section 26(1)(b) I make the following recommendations which may realistically prevent other deaths in similar circumstances in the future. All of these recommendations are directed towards the Police Service of Scotland.

I have noted below, in the Discussions and Conclusions section, a number of areas in which the Standard Operating Procedures as regards the custody and welfare of prisoners were not complied with. I have concluded that none of these contributed to Mr Hutton's death, however the evidence suggests that improvement in these areas could prevent future deaths of prisoners who are under the influence of drugs.

The SOP version 3 that was in use in 2016 has now replaced by the SOP version 13. This Inquiry has taken place in excess of three years after Mr Hutton's death, and this delay has not assisted the court in making these findings and recommendations. I make three recommendations:

(1) The welfare of prisoners has to be the priority for custody staff. The other duties that are covered by those staff, such as preparing prisoners for release, dilutes their ability to focus on the priority that is the prisoners' welfare. The Police Service of Scotland should review the staffing levels in the custody suite as well as the arrangements for deciding whether extra cover is required for the suite.

(2) Evidence was led that the SOP version 3 instruction to officers at paragraph 13.5.2 that a medical assessment should be sought if there is no visible improvement in a prisoner after 4 hours has not been repeated in SOP version 13. This should be reviewed. The PCSOs and custody staff are not medical professionals and cannot be expected to view prisoners from a medical perspective. It may well be that the 4 hour period was arbitrary. If a prisoner is assessed as vulnerable due to intoxication then some proactive system to monitor his or her progress may assist custody staff in looking after that prisoner's welfare.

(3) The cell sheet that was in use at the time of Mr Hutton's death did not have a separate column to show whether a prisoner had had food or water. Dehydration can be dangerous and can exacerbate other already existing conditions. A format that makes it immediately obvious to the reader what water and food a prisoner has, or has not, consumed may assist custody staff in looking after the welfare of that prisoner. The Police Service of Scotland

should review the cell sheet and consider whether a separate column to show food and drink intake would be of benefit.

NOTE

Introduction

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the 2016 Act because Mr Hutton was in legal custody at the time of his death. The purpose of the inquiry was to establish the circumstances of his death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[2] The Procurator Fiscal issued the notice of the inquiry on 8 March 2019. A preliminary hearing took place at Dundee Sheriff Court on 24 April 2019. This hearing was continued to 1 May and, on that date, the days of 24, 26 and 27 June were fixed for the Inquiry to take place.

[3] On the days of the Inquiry, the Crown was represented by Ms Davidson, Procurator Fiscal Depute, the family of Mr Hutton was represented by Mr Alonzi, Advocate, the Police Service of Scotland were represented by Mr Reid, solicitor, Tayside Health Board was represented by Ms MacNeil, Advocate and Mr Brian Conway was represented by Ms Lindsay, solicitor.

[4] The Inquiry was held on 24 June, 26 June, 27 June, 28 October and 29 October 2019.

[5] Some evidence had been agreed between the parties and this was presented to the court by way of the Joint Minute of Agreement.

[6] The Crown led evidence from:

Police Constable Stephen Cook, Police Sergeant George Martin, Police Sergeant Ian Taylor, Police Sergeant Gordon Gray, Doctor Bruce Henderson, Police Constable Scott Hunter, Police Custody and Security Officer ("PCSO") Brian Conway, PCSO Linda Peddie, Nurse Janine Watson and Doctor David Sadler.

[7] The Police Service of Scotland led evidence from: Chief Inspector Gordon Milne.

[8] No witnesses were led on behalf of any other party.

The legal framework

[9] This Inquiry was held under section 1 of the 2016 Act.

[10] The Inquiry was governed by the rules of the 2016 Act.

[11] The purpose of the inquiry was to establish the circumstances of Mr Hutton's death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[12] The public interest is represented at a Fatal Accident Inquiry by the Crown, in the form of the Procurator Fiscal.

[13] A Fatal Accident inquiry is an inquisitorial process.

[14] It is not the purpose of an inquiry to establish civil or criminal liability for Mr Hutton's death.

Summary

[15] The majority of the evidence was not in dispute.

[16] There were procedures that were in operation within the cell area at the time, and which are pertinent to this Inquiry. Instruction to staff about the care and welfare of prisoners was provided in the "Care and Welfare of Persons in Police Custody" Standard Operating Procedures ("SOP") manual version 3, which was in use at the time. This stated, amongst other things:

> **13.3 FREQUENCY OF VISITS**
>
> 13.3.1 The Custody Supervisor must personally inspect all custodies at the start and finish of each shift and where there is a transfer of responsibility for the custody, i.e. at shift changeover. It is important that shift changeovers include a thorough briefing on custody status… (Note; this has been removed and does not feature in the current SOP version 13.)
>
> 13.3.2 All custodies should be visited at least once per hour. It is a good practice to conduct visits at irregular intervals, reducing the opportunities for custodies to commit acts that would put their safety at risk. **At each visit, all custodies are to be roused and spoken to and are to give a distinct verbal response.** (Note; the highlighting was included in the SOP.)
>
> **13.5 DRUNK, DRUG OR SOLVENT CUSTODIES**
>
> 13.5.1 Custody Supervisors should review all the circumstances pertaining to an individual custody who was initially recorded as being under the influence of alcohol and/or drugs in the Custody Record, prior to updating them as sober on the Custody Processing System.
>
> 13.5.2 If there is no visible improvement to a custodies (sic) demeanour after 4 hours, a medical assessment should be sought. (Note; this has been removed and does not feature in the current SOP version 13.)

13.9 FEEDING OF CUSTODIES

13.9.1…..Staff are to ensure that custodies receive sufficient water whilst in custody.
13.9.5 …..Drinking water will be provided on request and should be served in polystyrene cups.

Each cell had a buzzer switch that the prisoner could press for assistance. When this was done a buzzer sounded in the staff room, and a light illuminated outside the cell door and remained illuminated until it was switched off outside the cell. Now, in 2019, each cell has a telephone that the prisoner can use to request assistance.

A blue disc was put on the cell door to denote a 30 minute check for that prisoner, and a red disc was put on to denote a vulnerable prisoner.

A cell sheet was fixed outside the cell door onto which the custody staff should enter details of each visit they made to the prisoner. There were four columns on the form. These were for: (1) the time of the visit, (2) the name of the custody officer making the visit, (3) any medication provided (including type and dosage), and (4) *"A distinct verbal response is required from high vulnerable prisoners on every visit. REMARKS: To include all movements, visits, fingerprints, photographing, interviews, meals, drinks etc."*

Food and water were not pre-provided in the cells.

[17] Mark Patrick Hutton ("Mr Hutton") was born on 26 May 1986 and lived in Dundee.

[18] In March 2016 Mr Hutton was in receipt of a prescription for a daily dose of 60ml of liquid Methadone from the Tayside Substance Misuse Service which was to be taken under supervision. His last such administration of Methadone happened between 09:15 hours and 12:30 hours on Friday 4 March 2016. At that time Mr Hutton also had prescriptions from his GP for eye drops and for Hyoscine patches to treat excessive sweating caused by the methadone.

[19] Mr Hutton was arrested by police officers, who were on a motorcycle patrol, at around 21:50 hours on Friday 4 March 2016 following an allegation of a contravention of section 4 of the Road Traffic Act 1988 (driving whilst unfit through drink or drugs), he having been reported to the police for allegedly riding his moped erratically in the Pitkerro Road area of Dundee. Those police officers had stopped Mr Hutton and noted that he appeared to be heavily under the influence of either drink or drugs. Mr Hutton provided a breath test at the roadside and this was negative for alcohol in his breath. The officers then required Mr Hutton to cooperate in a preliminary impairment test to assess his ability to drive. Mr Hutton did do so, but during the test the officers noted that his speech was slurred, that he was extremely unsteady on his feet and that he had to take hold of a lamp post to steady himself. The officers decided that he had failed this test. He was however able to stand unaided and was not staggering around.

[20] **Police Constable Stephen Cook** and Police Constable Jamie Hays of the Road Policing Unit arrived on the scene and took Mr Hutton to police headquarters, West Bell Street, Dundee. Before doing so the officers searched Mr Hutton for any harmful objects, but found nothing of any significance. This included searching his pockets, his arms, his legs, his waist and was described as a “top to bottom” search. Mr Hutton was noted to be under the influence but to be compliant with these police officers. PC Cook described Mr Hutton as being lucid, under the influence of something, chatting with the police en route to police HQ but having slurred speech. PC Cook had no concerns about Mr Hutton’s behaviour.

[21] Mr Hutton arrived at West Bell Street police office at 22:25 hours. At the charge bar his arrival was processed by Police Sergeant George Martin. Mr Hutton was not handcuffed whilst at the police station because he had not been assessed as being either a risk to himself or to police officers. Mr Hutton said that he had had a corneal transplant and required his eyedrops. Mr Hutton was asked a series of standard questions that are asked of all arrivals at the police office and he both understood and responded to those questions. Amongst other things, he said that he was not addicted to alcohol or drugs, felt drowsy because he had taken some Amitriptyline earlier that day, had never self- harmed, had never had any mental health issues, did not have any allergies and did have perforated eardrums. He did not say that he was on a prescription for methadone. Whilst at the charge bar the police officers searched his pockets, with his help, for sharp items. In the course of that search various items were taken out of his pockets including a pair of gloves, some pens, an L plate and a wallet. His outer and inner pockets were searched at this time. Items of clothing that contained any lengths of cord were removed from him.

[22] PC Cook was an experienced searcher and explained how the search was carried out included turning pockets out to reveal their contents and unzipping Mr Hutton's top.

[23] PC Cook noted that Mr Hutton had badly fitting false teeth which affected his speech to an extent. PC Cook said that Mr Hutton spoke to him about football and that he had only a little difficulty in understanding him. PC Hays did have trouble

understanding Mr Hutton but thought that this was because of his false teeth rather than because of intoxication.

[24] At 22:42 hours those officers carried out drink driving procedures in the Intoximeter Room. At around 22:45 hours Mr Hutton consented to being examined by a doctor in respect of whether he was under the influence of any intoxicant.

[25] PC Cook took Mr Hutton down to the cells at 22:52 and once there explained to the custody staff that Mr Hutton had been assessed as vulnerable, was to be put on a 30 minute watch and was to be given a full search. PC Cook gave the custody staff written documentation to this effect. PC Cook carried out a full strip search of Mr Hutton in the cell. Items of clothing were taken from Mr Hutton and he was given a pair of shorts. PC Cook found a small bottle in Mr Hutton's shorts which was removed. Mr Hutton said that this was his bottle of eyedrops. This search did not include any search of Mr Hutton's internal body cavities. This bottle of liquid was later analysed by the Scottish Police Authority Forensic Services and found to contain Diazepam, which is a class C controlled drug in terms of the Misuse of Drugs Act 1971. Mr Hutton was placed in cell 8.

[26] Mr Hutton participated in an impairment test that was conducted by a medical doctor in the medical room at West Bell Street at around 23:07. He failed this test.

[27] He refused to provide to PC Cook and PC Hay a sample of blood for further analysis at 23:31, stating, "shit scared of needles". He was then charged with refusing to provide a sample of blood and stated in response, "I'm petrified of needles".

[28] Mr Hutton was returned to cell 8 at 23:24. He was not searched at this time. He was told by PC Hay that he would be kept in custody until Monday 7 March when he would be taken to court. On being told this Mr Hutton shouted that he would, "take the fucking test". He was told that he could have a relative informed before he went to court. PC Hays thought that, at this time, Mr Hutton was heavily under the influence of drugs.

[29] At 23:10 hours Mr Hutton asked for water, but that request was refused on the advice of the nurse because he was yet to have his medical examination in respect of possible drug impairment. Mr Hutton was given a pair of his trousers and his top to wear and he was able to put those on unaided. These items of clothing had already been searched.

[30] **Police Sergeant George Martin** was a custody sergeant and was on duty from 16:00 on 4 March through to 02:00 on 5 March. He booked in Mr Hutton. He asked him the standard set of questions and noted that Mr Hutton said that he'd had Amitryptaline. He thought that Mr Hutton's speech was quite slurred and that he was under the influence of something. He did not have any concerns about Mr Hutton's presentation in the sense that he did not present as being in a dangerous condition, but because he was under the influence of something he was assessed as being at high risk and therefore required to be checked every 30 minutes.

[31] He printed out the form with these instructions on, and handed it to PC Cook and PC Hays to take with them when they took Mr Hutton down to the cells.

[32] PS Martin learned that Mr Hutton had failed the doctor's impairment test and then decided that he should be kept in custody for court the next day. Custody sergeants should do a hand-over at change of shift that includes a personal inspection of the prisoners. He said that he didn't do the latter, but he would have had the hand-over briefing with the sergeant who was taking over from him at 02:00.

[33] **Police Sergeant Ian Taylor** started at 01:00 on 5 March and said that he would have worked for the first hour with the finishing sergeant who would brief him in a hand-over. He recalled that there were about 20 prisoners, 9 of whom were on 30 minute checks and this was a pretty normal amount of prisoners. He did a brief check of the 9 prisoners who were on the 30 minute checks, but this did not include a visual inspection. He said that this was partly due to having to process another new prisoner. He did not visually check any prisoners and this could have been partly because of the number of other new prisoners. He said that there was nothing untoward about any of the prisoners during his shift. At 06:45 he handed over to PS Gray.

[34] **Police Sergeant Gordon Gray** started his shift by taking a hand-over in the sergeant's office from PS Taylor for 15-20 minutes. He learned that Mr Hutton had been under the influence of something and was therefore placed on 30 minute checks. He had three admin staff upstairs, two PCSOs in the cells and a nurse on duty. He thought that he had visually checked on Mr Hutton, and had noted this in his statement. But, on looking at CCTV footage in court, he stated that this must have been a false memory because there was no footage of this happening. His statement had been made at 16:20 that afternoon and he'd noted that, "I checked Mark Hutton in cell 8 to get a verbal

response, he looked up and said "yeah" and was clearly under the influence of something." He explained that he did 1500 to 2000 custody assessments every year, and his memory must have played him false as a result.

[35] PS Gray decided at the hand-over briefing that Mr Hutton's need for 30 minute checks should not change. He recalled the nurse telling him that Mr Hutton had had some medication for his eye and he remembered trying to find a contact number for Mr Hutton's mother in order to confirm this. He said that he was working up in the public office at around 13:00 when he heard the alarm being sounded. He went down to cell 8, spoke to other staff and ensured that an ambulance was called.

[36] PS Gray said that it wasn't unusual for a prisoner who arrived under the influence of drugs to remain so for a long time. Some prisoners don't improve at all, some only improve slightly – it all depended on the individual. It does not, of itself, raise concerns if a prisoner seems to remain under the influence for 12 hours.

[37] **Brian Conway** was a Police Custody and Security Officer ("PCSO") who started his duties at 07:00 on 5 March. He had 13 years of experience as a custody officer. He said that he was briefed when he started work and was told that there were 10 prisoners who were on 30 minute checks, of whom Mr Hutton was one. He was told that there were three prisoners for whom he would have to enter the cell in order to get a response, and Mr Hutton was one of these. He checked Mr Hutton's cell hatch at 07:24, 07:50 and at 09:03 and received the response, "yeah" or similar. At around 09:24 he brought breakfast but assessed Mr Hutton as unfit for breakfast because he was still sleepy due to the effects of drugs and might therefore be a choking risk when eating food. He was

aware that Mr Hutton was in a worse state than some of the other prisoners but had no concerns about Mr Hutton on any of these visits. He then went in to Mr Hutton's cell with nurse Watson at 09:27 when she went in to question him about his medication. At this time Mr Hutton was either asleep or ignoring him and had to be roused by way of a shake and an ear nip. Mr Hutton answered her questions about his medication. He did not mark this check on the cell sheet. PCSO Conway made checks of Mr Hutton's cell hatch at 09:57, 10:27 and 10:53, on each occasion getting the verbal response of, "yeah" from Mr Hutton. By error, the check due for around 11:30 did not take place. At 12:00 he went to the cell door hatch, got no response and entered the cell to give Mr Hutton a shake and an ear nip which prompted a response from him. He had no concerns for Mr Hutton at this check. His last check was at 12:55. At that time he received no response from Mr Hutton, entered the cell, shook him and on receiving no response to that he then got the nurse and summoned paramedics. PCSO Conway agreed that there were several occasions when custodies had buzzed for assistance, and their cell lights had illuminated, but had had to wait as much as 13 minutes for assistance to arrive from a PCSO. He said that this may have been due to him having to attend to other duties such as processing the prisoners who were to be released. He confirmed that Mr Hutton had not requested water from him at any point but that he did not know whether he had been given any water by the previous shift.

[38] **Linda Peddie** was a PCSO who shared this shift with PCSO Conway. She had been a custody officer for 26 years and was used to working with him. She said that she started at 07:00, was not involved in the hand-over briefing, and that PCSO Conway did

attend that briefing and then briefed her. They would have discussed which prisoners were on what length of check, who was due for release and who needed to be fingerprinted. She agreed that there were 24 prisoners, 9 on 30 minute checks and the rest on 60 minute checks and she thought that this was pretty busy. She made her first cell check of Mr Hutton at 08:19. She said that there was no particular reason why she did some checks and PCSO Conway did others. She said that she assessed another prisoner that morning as being unsuitable for breakfast. She checked Mr Hutton at 11:17 and got the response of "yeah" from Mr Hutton. They were moving prisoners into different cells and fingerprinting prisoners all through the morning. It took 5 to 10 minutes to fingerprint somebody. She said that she was used to dealing with prisoners who were under the influence of drugs and in her experience different people remained under the influence for different lengths of time. It wasn't unusual for prisoners to still be under the influence after a night in a cell. It wasn't unusual for prisoners to neither drink nor eat. She said that prisoners are only given food or water if they request it. Apart from looking to the welfare of the prisoners her duties included fingerprinting them, photographing them, taking them to the showers and taking them to see their solicitors. She thought that 24 prisoners was too large a number for 2 PCSOs to look after particularly because fingerprinting required both PCSOs to be present. PCSO Peddie remembered a death in the cells a few years ago and said that although staff numbers were increased after that, they had then dwindled because staff who left had not then been replaced. She described PCSO Conway and her as "running about like headless chickens" during this shift. She said that they could have asked for help but didn't do so

because when they had asked for help on previous occasions no help had been produced.

[39] By error, the visit due at around 12:30 did not take place.

[40] **Nurse Janine Watson** was on duty in the cells from 07:00 to 20:00 on 5 March. She had been a nurse for 31 years. She was one of two nurses on duty then. She was briefed at the start of her shift. She was told that Mr Hutton had failed an impairment test and that she had to follow up the issue of his eyedrops. No concerns about his condition were highlighted to her at the briefing. She went to see Mr Hutton at 09:27 in order to ask about his medication and because PSCO Conway had earlier come to her room and raised some kind of concern about him, although she couldn't remember what his concern was. She spoke to Mr Hutton from the hatch and then went in to the cell with PCSO Conway. Mr Hutton answered her questions directly and clearly and his demeanour did not give her any reason for concern. She recalled that there was no mention in the paperwork of Mr Hutton being on a methadone prescription but that she would not have treated him any differently if she known that he did have such a prescription. She described her efforts to revive Mr Hutton when she had been alerted and had gone to his cell at 12:56. She thought that Mr Hutton had already died by the time that she got to him. She did not know whether a 12:30 check might have prevented Mr Hutton's death. She had not been informed that Mr Hutton had not drunk any water since being in police custody but would have liked to have been told this.

[41] The cell sheet completed by the custody staff shows that visits were made at: 22:39, 22:55, 23:10, 23:24, 23:45, 00:17, 00:45, 01:15, 01:45, 01:52, 02:14, 02:45, 03:17, 03:45,

04:15 04:45, 05:20, 05:45, 06:15, 06:20, 06:50, 08:21, 08:55, 09:25, 09:55, 10:25, 10:50, 11:15 and 12:00. This shows that the visits appeared to have been made at intervals ranging from 5 minutes to 45 minutes.

[42] The CCTV footage does not entirely accord with the cell sheet timings. For example, the footage showed checks occurring at 07:24, 27 minutes later at 07:51 and 28 minutes later at 08:19. This shows that the 07:24 and 07:51 visits were made, but were not recorded on the cell sheet as they should have been. The footage shows that there was a visit at 11:17 but then a 43 minute gap until the next visit at 12:00, and that there was no further visit until Mr Hutton was discovered, unresponsive, at 12:55 hours.

[43] The 12:30 cell visit was missed, and the 11:30 visit was 15 minutes late.

[44] At no point was Mr Hutton offered, or provided with, food or water.

[45] At around 12:55 hours on 5 March 2016 Mr Hutton was found to be unresponsive in his cell, and then both PCSO staff and police staff took turns to administer cardio-pulmonary resuscitation to Mr Hutton. Paramedics attended at around 13:01 hours and they tried, unsuccessfully, to revive Mr Hutton. Mr Hutton's life was pronounced to be extinct at 13:29 hours.

[46] An investigating officer noticed what appeared to be a pinkish residue in the toilet bowl of cell 8. At 19:00 samples were taken of this and of the water in the bowl.

[47] **Doctor David Sadler**, consultant pathologist, carried out a post-mortem examination of Mr Hutton's body on 8 March 2016. He found the cause of Mr Hutton's death to be: 1 (a) Acute and Chronic Adverse Effects of Methadone, Diazepam and Etizolam and Possible Inherited Cardiac Abnormality.

[48] Doctor Sadler said that the information from 2015 in medical records about Mr Hutton's inherited electrical heart abnormality could have had a bearing on his death. However, this was a subtle abnormality. Many people can have this abnormality and not know anything about it. Its impact can range from insignificant to, on occasions, fatal. More often than not this type of abnormality is benign. Doctor Sadler believed that we will never know for sure whether Mr Hutton's heart abnormality had any part to play in his death. Doctor Sadler explained that the drugs in question can have a toxic effect in overdose, they can have unpredictable side effects and can have a chronic effect on the heart and brain. He said that Diazepam can contribute to respiratory depression when it is used in combination with Methadone and/or Etizolam. He believed that the drug traces found in Mr Hutton's system suggested that he was likely to have either taken his 60ml prescription on top of more methadone already in his system or to have taken his 60ml prescription and then topped up with more methadone. Doctor Sadler also said that he could not say for sure whether the level of drug traces were inconsistent with Mr Hutton only having had his 60ml prescription the day before, and this was because the post-mortem was carried out 3 days after Mr Hutton's death and the bodily processes over those 3 days may have impacted on the levels of drug that were found in his system.

[49] Doctor Sadler could not say whether Mr Hutton's lack of food or water whilst in custody had contributed to his death. It was possible that dehydration could have contributed to Mr Hutton's death to some degree but, if it had, he could not say to what degree. He stated that the amount of clear urine found in Mr Hutton's body suggested

that he was perhaps not dehydrated at the time of his death. Doctor Sadler could not say what the mechanism of Mr Hutton's death had been and he could not therefore say if Mr Hutton had been in a coma preceding his death or whether his death had been sudden. If Mr Hutton's death had been mainly drug-related then his breathing would have stopped first and then his heart would have stopped, whereas if it was mainly related to heart failure then his heart would have stopped first followed by his breathing. Doctor Saddler could not say whether another check on Mr Hutton by staff could have prevented his death. He said that another check may have helped Mr Hutton if Mr Hutton had been in a coma, but even then he could have been roused by staff from the coma, and then have slipped back into it again.

[50] The samples that had been taken from the toilet bowl in cell 8 were later analysed and found to contain desmethyldiazepam, Methadone and EDDP. Dr Sadler advised the court that desmethyldiazepam is a metabolite of Diazepam and that EDDP are metabolites of Methadone. He said that metabolites occur when Diazepam and Methadone break down in the body. Dr Sadler suggested that Mr Hutton could have had these metabolites in his urine and then excreted them when he went to the toilet. The toilet had been flushed by PCSO Conway at 07:24.

[51] **Chief Inspector Gordon Milne** is the head of the custody division in Tayside. He has reviewed and helped to formulate police custody procedures. He said that there are currently around 400 police Standing Operating Procedure ("SOP") documents. The SOPs are there to provide guidance to police officers. The SOP For the Care and Welfare of Persons in Police Custody that was in use in 2016 was version 3. The SOP for this that

is now in use is version 13. In the past, SOPs were amended in a way that tended to be reactive and as a result of specific incidents in an approach that was more risk-averse than the modern one. The modern approach is a more measured assessment of the need for change. SOPs tend to be wordy and are, as a result, sometimes not as user-friendly as they could be for front line staff. The Police Service of Scotland is currently trying to assess which SOPs are needed, trying to introduce those SOPs into digital form and trying to shorten them in order to make them more user-friendly.

[52] CI Milne said that of the Custody SOPs, version 13 was more realistic than version 3. Version 3 was a result of immaturity of understanding of what actually happens in custody situations, is a more mechanistic approach and is not achievable in all the circumstances. He pointed out that whereas version 3 had required that a custody *supervisor* personally inspect all custodies, version 13 states that a custody *officer* should inspect all custodies. The supervisor was usually a sergeant whereas a custody officer could be an experienced constable working in, or drafted into, the custody environment.

[53] CI Milne said that the instruction to officers at paragraph 13.5.2 of the custody SOP version 3 that a medical assessment should be sought if there is no visible improvement in a prisoner after 4 hours has not been repeated in SOP version 13. The reason for this is that a mature understanding of what actually happens in custody shows that if a prisoner has received a properly carried out custody assessment, there should be no need for ongoing assessment. DI Milne said that the 4 hour period set out in custody SOP version 3 was mechanistic and arbitrary. If staff should have any concern about a prisoner's demeanour then they should contact the nurse.

[54] CI Milne agreed that paragraph 13.9.1 of custody SOP version 3 stated that staff should ensure prisoners receive sufficient water whilst in custody. However he said that this wasn't quite as simple as it seems because of safety issues. Plastic cups have been used in the past for self-harm and polystyrene cups have been used for self-harm by choking. So, if a prisoner requests water, they can have as much as they want as long as it is delivered, and its consumption is supervised, by custody staff. The police approach is to carry out a comprehensive risk assessment at the start of a prisoner's time in police care and to identify the risks and dangers properly at that point. He would only rule out leaving drinking vessels with a prisoner if a risk of some sort has been identified.

[55] CI Milne said that it is the responsibility of custody sergeants to identify if custody staff are overstretched, and if so to then 'flex' other staff from other places to assist. He would expect that the sergeant would be able to find some staff from other places and would expect the sergeant to monitor the risk assessments of custodies as they arrive and are booked in. He would expect custody sergeants to monitor what is going on in the cell areas and to actively check if PCSOs need help, and even assist them themselves when necessary. He said that the PCSO staff deal with many people who don't want to be in custody and who will use ruses to try to get out of their cells. The PCSO staff are trained to look out for markers of deterioration in prisoners such as sweating, becoming quieter or not engaging.

[56] Parties requested time to submit written submissions after the evidence had concluded. I agreed with this suggestion and gave them until 19 November for this to be done. I have included these written submissions below.

Discussion and Conclusions

[57] When someone is in police custody, he or she is entirely dependent on the Police Service of Scotland (PSS) staff for his or her health and well-being. The PSS has a duty of care to those people who find themselves in its custody. The PSS has a difficult task in balancing a range of factors when it comes to meeting that duty of care. These factors include: the condition of the prisoner when in custody, the attitude of the prisoner towards the custody staff and the services that they can provide, the right of the prisoner to refuse services, the right of the prisoner to be treated with dignity and to expect some amount of rest and the risk factors (for the prisoner and for staff) involved in providing services to the prisoner. The police SOPs are documents that have evolved over time in an effort to help staff to achieve that duty of care on behalf of the PSS.

[58] Mr Hutton entered the custody of the PSS alive. But he died whilst in the custody of the PSS. Was there any act or failure on the part of the PSS that contributed to Mr Hutton's death?

[59] I am satisfied that Mr Hutton's condition was properly assessed as vulnerable - because of being under the influence of drugs - by the police officers who stopped him, arrested him and processed him at West Bell Street.

[60] On arrival at West Bell Street he was correctly assessed as being vulnerable whilst in police custody and was correctly assessed as requiring half hourly checks.

[61] This being the case, it was thereafter incumbent on the PSS staff to look after Mr Hutton and, as part of that process, to have regard to the guidance that was then provided in version 3 of the custody and care SOP which I set out above.

[62] From the outset it is crucial to bear in mind that the cause of Mr Hutton's death has been ascertained as being drug-related with a possibility of a contribution from his inherited cardiac abnormality. It seems more likely that the principal cause of death was the combined effects of Methadone, Diazepam and Etizolam, but that cannot be stated with certainty. There is no evidence that can tell us whether Mr Hutton's death occurred after a period of coma, or whether his death was a sudden event.

[63] It is clear that 15 hours elapsed between Mr Hutton entering into police custody at 21:50 on 4 March and his being discovered unresponsive at 12:55 on 5 March 2016. Over these 15 hours he was not provided with food or water. The instruction 13.9.1 in the SOP that "staff are to ensure that custodies receive sufficient water whilst in custody" was not complied with. It cannot be good for any person, in any condition, to go without some form of hydration for such a lengthy period of time. However, there is no firm evidence that Mr Hutton was dehydrated or that dehydration may have been a factor in his death. There is no evidence that leads me to conclude that this lack of food and water contributed towards Mr Hutton's death.

[64] Mr Hutton should have been checked every 30 minutes. Checks were made at intervals of between 5 and 45 minutes, and they were made in every 30 minute period bar one. The 11:30 check was 15 minutes late. The check that was missed altogether should have been at around 12:30. Whilst the 12:30 check should have happened, in the

absence of any evidence to show what condition Mr Hutton was in at 12:30, I cannot conclude that a check at 12:30 would have prevented his death.

[65] At no point after Mr Hutton had spent 4 hours in police custody did any of the custody staff decide that he had not shown any signs of improvement in his condition and that the nurse should be informed of this. (Note: Nurse Watson thought that PCSO Brian Conway had approached her with some sort of concern about Mr Hutton, but PCSO Conway didn't recall doing this, and she couldn't recall what the concern had been). According to SOP version 3 this is something that most likely should have been done any time after around 03:15. The PCSO staff said that they did not have any concerns for him. But the responses from Mr Hutton consisted of little more than "yeah" when the cell checks were made, and that cannot have demonstrated a noticeable improvement in his condition. When nurse Janine Watson saw Mr Hutton at 09:27 she spoke to him and had no concerns about his demeanour or condition. The SOP instruction at 13.5.2 that "If there is no visible improvement to a custodies (sic) demeanour after 4 hours, a medical assessment should be sought" was not complied with. However, given that a professional nurse had no concerns about him at around 09:27, there is no evidence that leads me to conclude that this failure to notify her from 03:15 onwards that Mr Hutton had not shown signs of improvement contributed to his death.

[66] There were only two PCSO staff on duty looking after 24 prisoners. Their duties consisted not only of looking after the welfare of prisoners whilst they were in their cells but also of processing them in preparation for them being released. As the morning of 5

March unfolded, more and more prisoners were being moved or released and required to be fingerprinted by the PCSO staff. Two officers have to be present when fingerprinting is carried out. The PCSOs' focus on Mr Hutton's welfare was distracted, and degraded, by these competing duties. They should have noticed that he hadn't had any water since arrival, and they should have remembered to check him at 12:30. However, there is no evidence that leads me to conclude that these failures contributed towards Mr Hutton's death.

[67] The SOP version 3 at 13.3.1 required that the "Custody Supervisor must personally inspect all custodies at the start and finish of each shift." This was not complied with. There was no personal inspection of Mr Hutton by the Custody Supervisor at the end of Sergeant Martin's shift, at the start and end of Sergeant Taylor's shift, nor at the start of Sergeant Gray's shift. All of those Custody Supervisors did, however, brief each other verbally about all of the prisoners at the start and end of each shift, and the briefing information was disseminated to the other custody staff. There is no evidence that suggests that failures to personally inspect Mr Hutton by the Custody Supervisors contributed to Mr Hutton's death.

[68] The SOP version 3 at 13.3.2 required that "All custodies should be visited at least once per hour….At each visit, all custodies are to be roused and spoken to and are to give a distinct verbal response." The cell sheet for cell 8 shows that "Yeah" is recorded as the response that Mr Hutton gave on 12 out of 25 checks. Other comments were: "Aye" on 3 occasions, "OK" once, he was roused on 4 occasions and was sleeping/snoring on 3 occasions. The CCTV footage showed that many of the checks consisted of a very brief

opening of the cell hatch by the PCSO. The evidence from the officers was to the effect that sometimes this was all that was needed to get those responses because once prisoners are used to the routine of the hatch being opened they make the required comment as the hatch is in the process of being opened. This requirement was not complied with to the letter because there were three occasions when Mr Hutton was not roused but was just noted as snoring. These were judgement calls made by the PCSOs because a prisoner may well benefit from being left to sleep undisturbed. The PCSOs were experienced and were satisfied with Mr Hutton's responses and that he was snoring. In the ten checks that were made prior to Mr Hutton being found unresponsive at 12:55 he gave responses that raised no concerns on the part of the PCSOs. I cannot conclude that the failure to follow this requirement on those three occasions contributed to Mr Hutton's death.

[69] Paragraph 13.5.2 in version 3 of the custody SOP has been deleted and does not appear in the current version 13. It may well be that the 4 hour period used in version 3 was an arbitrary time for custody officers to review the condition of a prisoner. However, given that the custody staff are not medically qualified, they need all the guidance they can get about how to monitor the health of a prisoner who is deemed to be vulnerable due to being under the influence of drugs. Medical help is at hand from the nurses, but the custody staff do need guidance about when to seek that help.

[70] The welfare of prisoners has to be the priority for PCSO and other custody staff. It became obvious during the Inquiry that two members of staff was an inadequate number of staff to look after the welfare of 24 prisoners once decisions were being taken

to release some of the prisoners. This is because those prisoners then had to be prepared for release. This involved arranging for, amongst other things, showers and fingerprinting. There were arrangements in place for PCSOs to ask for assistance and a requirement for Custody Supervisors to proactively keep an eye on the pressures that the CPSOs were under and to adjust staffing levels accordingly. The failure to obtain more staff did not contribute to Mr Hutton's death, but it did mean that, in practice, the welfare of Mr Hutton took second place to the processing of the prisoners who were due to be released.

[71] Overall, the systems that were in place at the time were adequate for the purposes of looking after the welfare of prisoners. Those systems were not followed as closely as they should have been in some aspects, however those failures did not contribute to Mr Hutton's death.

I take this opportunity to express my condolences to Mr Hutton's family. I wish to commend those family members who came to the Inquiry for the dignity with which they conducted themselves whilst listening to what must have been distressing evidence.

APPENDIX

CROWN SUBMISSIONS

In terms of Section 26 of the Fatal Accident and Sudden Deaths etc. (Scotland) Act 2016, I respectively invite your Lordship to make findings in the following terms:

Section 26 (2)(a) – When and where the death occurred

Mark Patrick Hutton, born 26th May 1986, resident [in] Dundee, died at 13:29 hours on 05th March 2016, at Cell 8, Tayside Divisional Headquarters, West Bell Street, Dundee.

Section 26 (2)(b) – When and where any accident resulting in the death occurred

The Crown is not seeking formal findings in terms of this provision.

There is no evidence that Mr Hutton died as a result of an accident.

Section 26 (2)(c) – The cause of death

Under reference to Crown Production 2, Post Mortem Report, the cause of death was 1(a) Acute and Chronic Adverse Effects of Methadone, Diazepam and Etizolam and Possible Inherited Cardiac Abnormality.

The court heard evidence from Dr Sadler, Forensic Pathologist that he could not categorically state whether Mr Hutton died of respiratory failure brought on by the acute and chronic adverse effects of Methadone, Diazepam and the street drug Etizolam. This cause of death may have occurred over a period of time, which Dr Sadler categorised as sleeping followed by coma then death. He did state in evidence that

Mr Hutton could have been roused from sleep but then minutes later lapsed into coma then death. **Or** as a result of previously diagnosed Long QT syndrome which could have caused death suddenly and without warning. There was evidence from witnesses that Mr Hutton did not receive any food or water whilst in his cell, however, Dr Sadler stated that at post mortem Mr Hutton's bladder contained 100 mls of clear yellow urine which Dr Sadler was of the view suggested that dehydration was not a factor. He stated that if Mr Hutton's urine was dark and concentrated that would have suggested dehydration. The colour and amount of urine present at post mortem indicated that Mr Hutton was not dehydrated at time of death. Dr Sadler referred to Crown Production 2, Post Mortem report and his findings at autopsy in stating that Mr Hutton's lungs were full of fluid, Dr Sadler said this finding is common in both drug related and cardiac related deaths. This does not take us further in establishing whether Mr Hutton died as a result of acute and chronic drug use or of pre-existing cardiac complications.

Section 26 (2)(d) – The cause or causes of any accident resulting in the death

The Crown is not seeking formal findings in terms of this provision.

There is no evidence that Mr Hutton died as a result of an accident.

Section 26 (2)(e) - Any precautions which – (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided

The Crown is not seeking formal findings in terms of this provision.

Mr Hutton was brought into custody at 22:40 hours on 4th March 2016. On presentation at the Charge Bar witness Sergeant George Martin considered after risk assessment that Mr Hutton appeared to be under the influence of drugs and he deemed him a high risk prisoner. Sergeant Martin placed Mr Hutton on a risk management plan and placed him on 30 minute observations. He also instructed that Mr Hutton be strip searched and was to be seen by the Force Medical examiner. There was no evidence presented by any of the witnesses, nor evidence from the CCTV footage that intimated that Mr Hutton should have been placed on constant observations. The risk management plan set by Sergeant Martin was reviewed by Sergeant Iain Taylor at 01:53 hours. Although Sergeant Gordon Gray did not note he reviewed Mr Hutton's risk assessment on the cells sheets, he gave evidence that he carried out a verbal handover with Sergeant Taylor and agreed that the 30 minute observations of Mr Hutton continue.

We heard evidence from a number of the witnesses that it was not uncommon for a prisoner in custody to not eat food nor to drink anything. Mr Hutton could have used his buzzer at any time to ask for a drink or for food. He could have also asked any of the witness for a drink during the observation checks, further, he could have asked Nurse Watson for a drink when she checked on him at 09:27 hours. I have commented earlier regarding the autopsy findings in relation to Mr Hutton being dehydrated.

Mr Hutton was seen by Dr Henderson when he carried out an impairment assessment. Said assessment was carried out due to the nature of the offence Mr Hutton was arrested for rather than for a medical reason. Dr Henderson was satisfied that Mr Hutton did not require any medical attention and there was nothing concerning regarding his

presentation. Dr Henderson said Mr Hutton's demeanour was no different to the majority of prisoners he carried out assessment for. Witness Nurse Janine Watson also visited Mr Hutton in his cell at 09:27 hours to check details regarding Mr Hutton's prescription for specialist eye drops. Nurse Watson was also satisfied that Mr Hutton did not require any medical attention, she gave evidence that he was able to answer her questions and tell her what pharmacy he got his prescription from. There was no evidence presented by the two health care professionals that in their dealings with Mr Hutton that he required medical attention.

When Mr Hutton was found unresponsive in his cell at around 12:55 hours, he received immediate resuscitation from Nurse Watson assisted by police personnel until the arrival of paramedics approximately 5 minutes later. CPR continued for over 30 minutes before life was pronounced extinct. There is nothing to suggest Mr Hutton did not receive appropriate resuscitation efforts. Further, Mrs Watson stated in her professional opinion that Mr Hutton was already dead when she went to his cell.

So far as subsection (e) is concerned and having regard to its precise wording, it is difficult to identify what precautions might reasonable have been taken which might 'realistically' have avoided the death of the deceased.

<u>Section 26 (2)(f) – Any defects in any system of working which contributed to the death or any accident resulting in the death</u>

The Crown is not seeking formal findings in terms of this provision.

There is a system in place for assessing risk in respect of custodies, and human error aside, it did operate in that Mr Hutton was appropriately deemed high risk and placed on 30 minute observations. It is accepted that Sergeant Taylor did not visit the deceased at the start nor the end of his shift. There were failures in regard to record keeping and not all checks were carried out on time. Sergeant Taylor said he relied upon the experience of PC Scott Hunter and PC Debbie Spittal to bring to his attention whether Mr Hutton required medical attention. No concerns were brought to Sgt's Taylor's attention. Sergeant Gordon Gray at the start of his shift missed checking Mr Hutton's cell, this was human error rather than a defect in a system of working. Police Custody Officers Brian Conway and Linda Peddie carried out 12 checks on Mr Hutton during their shift. The court had the benefit of CCTV footage which showed these checks occurring at 07:24, 27 minutes later at 07:51, 28 minutes later at 08:19, 44 minutes later at 09:24, 3 minutes later by the nurse Janine Watson at 09:27, 30 minutes later at 09:57, 30 minutes later at 10:27, 26 minutes later at 10:53, 24 minutes later at 11:17, 43 minutes later at 12:00 hours with the final check at 12:55 hours. It was accepted that some checks were missed and some were late. Mr Conway and Mrs Peddie both said this was caused by them having 24 custodies with 9 of them being on 30 minute observations, that as well as providing breakfast for all prisoners, they had to fingerprint them, release some and move some prisoners to other cells. There was however, a system for carrying out checks in place. Mr Conway or Mrs Peddie could have asked for assistance from Sergeant Gray at any time, but did not do so.

The responses elicited from Mr Hutton during the checks and recorded on Crown Production 21, Cell Sheets appeared to be at variance from that required in Crown Production 17 Care and Welfare of Persons in Police Custody Standard Operating Procedures (SOP). We heard from Chief Inspector Gordon Milne however, that 'distinct verbal response' could be 'aye' 'a grunt' or it could be looking at someone lying reading a book. Chief Inspector Milne advised the court that there is now a new version of the Care and Welfare of Persons in Police Custody SOP in which Police Scotland have relaxed rousing a prisoner every 60 minutes for various reasons, including human rights, and the fact that some prisoners will have court in the morning or will be required to be interviewed. Chief Inspector Milne also told the court that section 13.5.2 of Crown Production 17 the Care and Welfare of Persons in Police Custody SOP "*If there is no visible improvements to a custodies demeanour after 4 hours, a medical assessment should be sought.*" has been deleted. The reason for this according to Chief Inspector Milne is that the 4 hour figure is an arbitrary figure and he would prefer custody staff to be more objective. Chief Inspector Milne said he would expect and rely on a Police Custody Officer to notice a deterioration or change in demeanour of a custody, and to bring this to the Custody Supervisors attention.

Section (2)(g) – Any other facts which are relevant to the circumstances of the death

I refer your Lordship to the Joint Minute of Agreement signed by all parties and lodged in terms of Rule 4.10.

It cannot be stated conclusively that Mr Hutton took more methadone on top of his prescription. We do know however that he did ingest street diazepam (Etizolam) and he was found to have diazepam in a small bottle concealed on his person. Mr Conway was seen on CCTV and gave evidence that he flushed the toilet for Mr Hutton's cell at 07:24 hours, said toilet water was analysed and found to contain Desmethyldiazepam, Methadone and EDDP. Dr Sadler advised the court that desmethyldiazepam is a metabolite of Diazepam and that EDDP are metabolites of Methadone. Metabolites occur when Diazepam and Methadone break down in the body. Dr Sadler suggested Mr Hutton could have secreted these substances in urine. Dr Sadler also told the court that Mr Hutton's methadone level was higher than would have been expected after receiving his 60 ml prescription that morning, however, Dr Sadler stated that post mortem drug levels cannot be accurately relied upon. Given the difficulties with establishing whether death was as a result of drug use and abuse or cardiac related it is difficult to ascertain the consequences of Mr Hutton's drug intake.

Finally, I tender my own sincere condolences, as well as those of the Crown to Mr Hutton's family and friends.

Donna Davidson

Procurator Fiscal Depute

Dundee

15 November 2019

WRITTEN SUBMISSIONS for the Family of the Deceased in the INQUIRY INTO THE DEATH OF MARK PATRICK HUTTON

On behalf of the family of Mark Patrick Hutton (the deceased) the following submissions are respectfully made with reference to Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016:

1. **S26(2)(a):** Mark Patrick Hutton died on 5 March 2016 within Cell 8 at Dundee Police Office, West Bell Street, Dundee. The time of his death is uncertain.

2. **S26(2)(c):** The cause of death is uncertain; it is unknown whether death was sudden or gradual. The Forensic Pathologist, Dr David Sadler accepted in cross-examination that whatever the cause of death, hydration would have improved the chances of survival. He said in re-examination that the presence of 100 mls of clear yellow urine would not "scream dehydration," but he also said that the body is continually producing urine; he also said that dehydration was not something easily diagnosed at post-mortem. It is submitted that, whether or not the deceased had reached a *medical* state of dehydration, Dr Sadler's position in cross-examination is nonetheless relevant, and if the deceased had been given water his chances of survival could have been improved. The deceased had been in police custody since his arrest at 2150 on 4 March 2016. PC Stephen Cook said that the deceased had asked for water at around 2300, but this request was refused on advice from the nurse that he should not be given water until he had been seen by the doctor. Ultimately the deceased received no water at all before he died.

3. **S26(2)(e) and (f) and (g):** The Police and their staff failed to comply with the terms of the Police Standard Operating Procedures (SOP) (Crown Production 17). Paragraph 13.5.2 states “If there is no visible improvement to a custody’s demeanour after 4 hours, a medical assessment should be sought.” The manner in which the observations on the Written Submissions for Family of Deceased FAI - Death of Mark Patrick Hutton deceased were performed was inadequate to enable the Police and their staff to see whether there was any change in demeanour. Sergeant George Martin was initially the custody supervisor until a shift changeover between 0100 and 0200 when Sergeant Ian Taylor took over the role of custody supervisor. Neither officer performed the necessary personal inspections required under paragraph 13.3.1 of the SOP at the start and finish of shifts. In evidence Sergeant Taylor gave the explanation that he was too busy. In turn, the role of custody supervisor then passed to Sergeant Gordon Gray who did not comply with paragraph 13.3.1 either, and in contrast with the “false memory” he had at the time of preparing his statement, he never in fact saw the deceased before he died. Furthermore, the minimal engagement with the deceased and the level of response obtained from him on the half-hourly checks that were carried out by other officers and staff was inadequate for any assessment of the deceased’s condition or demeanour. It is evident from the CCTV evidence that on many occasions the hatch was barely opened.

At 0545 PC Scott Hunter, having failed to get a response through the hatch, entered cell 8 and exited again a few seconds later; he left the light on in the cell and did not record

any verbal response on the cell sheet (Crown Production 21). On the next round of observations, at 0614 PC Hunter entered cell 8 directly this time without looking through the hatch; again he exited a few seconds later, left the light on and did not record a verbal response. PC Hunter said in evidence that the light would be left on for high risk custodies. Brian Conway said in cross-examination that when he came on duty he was told of certain prisoners, the deceased being one, that he would require to check by going into the cell. Later in cross-examination, when he was asked more about this, he said that PC Hunter had conveyed to him his heightened concern about the deceased.

By 0925 at the latest, when Brian Conway decided that the deceased was unfit to be given breakfast there ought to have been some concern for the deceased's wellbeing and a formal medical assessment ought to have been carried out. At the very least, the fact that the deceased had had nothing to eat or drink for at least 12 hours ought to have been focussed, and the need for some degree of closer monitoring of the deceased ought to have been apparent. However, none of this was even brought to the attention of the nurse, Janine Watson, who only coincidentally had cause to visit briefly cell 8 soon after Mr Conway decided not to provide breakfast. The decision not to provide breakfast ought to have been kept under review; and drink should have been provided. Instead, nothing was done. Following the nurse's visit to cell 8 at 0927, Mr Conway visited the cell on 5 occasions up to 1200 and during this period Mr Conway did not notice the deceased to have moved. Throughout this time the fact that the custodies in the neighbouring cells one by one were being downgraded and moved to other cells ought

to have highlighted even further the absence of any improvement in the deceased's demeanour. By 1200 it was 14 hours after the deceased had been taken into Police custody, and plainly no consideration was being given to the terms of paragraph 13.5.2 of the SOP. Instead, Mr Conway left the deceased unchecked in his cell for a further 55 minutes before the fatal discovery.

Far from there being any "visible improvement" in terms of paragraph 13.5.2 of the SOP, there was in fact a marked deterioration from the deceased's initial presentation as spoken to in evidence by PC Cook and Dr Henderson. This went unnoticed or was simply ignored in all probability for the same reason that the staff were too busy to respond to the buzzer/red light. Despite the fact that cells 1 to 8 were all categorised as high risk, the buzzer/red light was repeatedly left unanswered for several minutes without the staff knowing the degree of urgency involved. The CCTV recording gives a real sense that as the neighbouring cells were vacated and gradually the deceased became the only custody left in that corridor, the attention of the staff on duty was all focussed elsewhere.

Linda Peddie who was on duty along with Mr Conway said in evidence that if she felt a custody was unfit for breakfast she would tell the nurse. She listed a number of other duties that the staff had to deal with in addition to the welfare of the custodies. She confirmed that it was a particularly busy shift and said that they were running about like headless chickens. She said that the staff upstairs would know how busy they were,

and if they asked for help they would not get it. She said staff had left and had not been replaced. This echoed something said by Mr Conway in his evidence.

The nurse, Janine Watson had been unaware that Mr Conway withheld breakfast and that the deceased had had nothing to drink since being taken into police custody. During her evidence it appeared that Ms Watson had only learned recently that the deceased had not been given water; she said it "would ring alarm bells" if she had known; and she became visibly upset, asking, "why have we not been told about this earlier?" She said that if she had known this she would have assessed the situation differently.

19 November 2019

Lorenzo Alonzi Counsel for Family of Deceased

instructed by Caird Vaughan Solicitors 3

SUBMISSIONS FOR THE CHIEF CONSTABLE

INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS, ETC

(SCOTLAND) ACT 2016

Background

The background to the arrest and detention of the late Mr Hutton is narrated in Paragraph 2 of the Rule 4.10 Joint Minute of Agreement signed by all the Participants and lodged.

Section 26(2)(a)

Where and when the death occurred.

Paramedic Fiona Reilly pronounced life extinct at 13.29 hours on 5 March 2016 at Cell 8, Dundee Police Office, West Bell Street, Dundee. Participants' agreement is contained within the Rule 4.10 Joint Minute.

Section 26(2)(b)

When and where any accident resulting in the death occurred.

This death was not the result of an "accident" as such.

Section 26(2)(c)

The cause or causes of the death.

A Post Mortem was carried out on the late Mr Hutton and the Report is Crown Production 2. (**CP2**)

The Forensic Pathologist Dr David Sadler found the cause of death to be 1a. Acute and Chronic Adverse Effects of Methadone, Diazepam and Etizolam and Possible Inherited Cardiac Abnormality. (Rule 4.10 Joint Minute and **CP2**).

Section 26(2)(d)

The cause or causes of any accident resulting in the death.

The death was not the result of an accident.

The Other Subsections of the 2016 Act, Section 26(2)

In Fatal Accident Inquiries there can be an overlap or potential overlap between three subsections.

Section 26(2)(e)

Any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.

Section 26(2)(f)

Any defects in the system of working which contributed to the death or any accident resulting in the death.

<u>Section 26(2)(g)</u>

Any other facts which are relevant to the circumstances of the death.

<u>The Evidence and Issues Arising</u>

Following his arrest and his failure of a Preliminary Impairment Test Mr Hutton was taken to Dundee Police Office. He appeared to be heavily under the influence of drugs and was taken to Dundee Police Office. His arrival at the Custody Suite was timed at 22.25.

The relevant Custody Supervisor was Sergeant George Martin.

Paragraphs 4 to 9 of the Joint Minute of Agreement narrate his admission into custody and in particular the risk assessment. As a consequence of the risk assessment Sergeant Martin instructed that Mr Hutton be given a strip search and that he should be checked every thirty minutes (**CP21**).

The strip search of Mr Hutton did not disclose any drugs. As a consequence if Mr Hutton did have any drugs in his possession they would have had to have been either internally placed or ingested. The search did disclose a bottle of liquid in Mr Hutton's possession possibly a treatment for a previous cornea transplant. In fact subsequent analysis disclosed the bottle contained Diazepam.

An Impairment Test was carried out by Doctor Bruce Henderson and the documentation is **CP24**.

Doctor Henderson did say that there were signs of impairment. When asked if he had any concerns over Mr Hutton, for example whether or not he should have been referred to Ninewells, Doctor Henderson said "Not at all". He saw nothing unusual with Mr Hutton's presentation and he didn't present as being of any concern. There were no red flags. His demeanour was no different from that of the majority of custodies he had to assess.

Risk Assessment

The Assessment was carried out by Sergeant Martin. He took Mr Hutton through the procedure and entered the appropriate answers. The available information included the fact that Mr Hutton had had an eye operation and there was a complaint about his ear drum. Neither of these points was recorded although it is submitted they made no difference to the overall position.

At the Charge Bar Mr Hutton was apparently able to walk unaided although he was unsteady on his feet. He answered all the questions put to him. There was nothing to indicate to Sergeant Martin that Mr Hutton required immediate medical attention.

As a result of the assessment Sergeant Martin considered that Mr Hutton's vulnerability should be classed as "high risk" and that he should be placed on thirty minute observations. It was considered he was under the influence of drugs.

Handovers

Sergeant Iain Taylor came on duty at 0100 as Custody Sergeant. He spoke to the two Sergeants working together for an hour or so. He explained that there was a handover with Sergeant Martin when they discussed all the prisoners' risks and vulnerabilities and the intended disposals. He said that he thought there were about twenty custodies which he described as a normal weekend. He spoke to reviewing what was on each individual cell sheet and reviewing each set of documents for the custodies.

In respect of Mr Hutton specifically, he was advised that he had been arrested two or three hours earlier, he was believed to be under the influence of drugs and because of the problem with drugs Mr Hutton had been placed on half hourly checks.

Sergeant Gordon Gray came on duty at around 0640 and took over as Custody Supervisor from Sergeant Taylor. He too spoke to the handover procedure and to his handover from Sergeant Taylor. Again in relation to Mr Hutton, no concerns were expressed other than that he was under the influence of drugs and was on thirty minute checks.

Sergeant Gray went to check on the custodies following the handover. In the corridor which contained cells 1 to 8, Mr Hutton being in cell 8, he checked cells 1 to 7 but missed cell 8.

So far as the PCSOs were concerned, they either participated in the handovers with the Sergeants or had their own handover, one shift to the next.

<u>Recording of Custody Contact</u>

The Prisoner Custody Record, referred to as the cell sheet, should contain an accurate record of all checks. With a certain allowance for other duties impinging on checks, checks should be carried out at the appropriate time intervals as per the risk assessment, or any alteration thereof on review.

As already mentioned, Sergeant Gray missed a check. His PCSOs Brian Conway and Linda Peddie carried out checks up to and including 0924, as recorded on **CP21**.

At 0927 Janine Watson one of the custody nurses visited Mr Hutton. Although there was some confusion as to whether she had been asked to attend or attended of her own volition to check the eye drop position, she nevertheless did attend. She was satisfied with Mr Hutton's responses.

There were checks at 0957, 1027, 10.53 and 11.17. There was then a 44 minute period until a check at 1200 and then the check at 1255.

Medical assistance was sought and Janine Watson attended. CPR was commenced and continued when the paramedics arrived.

CP17 required a distinct verbal response. Chief Inspector Milne said that a grunt or "aye" was acceptable. If a custody was lying in the cell reading a book then that too would be acceptable (although technically not a verbal response). He also made reference to a change in the SOP where after 6 hours it may not be a requirement to rouse a custody (para. 15.2.1).

<u>Inspections at the Start and End of each Shift</u>

The outgoing Custody Supervisors did not inspect the custodies at the end of each shift. Standard Operating Procedure (SOP) **CP17** V3 28.10.15 is the Version relevant to this Inquiry. Para. 13.3.1 refers to the Custody Supervisor personally inspecting all custodies at the start and finish of each shift etc. This has been replaced by Para. 5.3 in Version V13 (**CCP1**) and in particular Para. 5.3.1 which does not require the Supervisor to personally inspect at the end of his/her shift.

Chief Inspector Milne gave evidence in relation to a SOP being an ongoing work. Originally, amendments tended to reflect specific incidents. It was impossible to draw a SOP to cover every possible eventuality.

<u>Medical Assessment after 4 Hours</u>

CP17 V3 Para.13.5.2 refers to seeking a medical assessment if there is no visible improvement to a Custody's demeanour after 4 hours etc. This is not contained in the current SOP, **CCP1**.

Chief Inspector Milne said that in his view 4 hours had been an arbitrary period. Custody staff should be more objective in assessing the needs of a prisoner. The PCSOs were experienced. On that basis he would expect and rely on PCSOs to firstly notice any change and/or deterioration in the demeanour of a custody and then draw this to the attention of the Supervisor.

Provision of Food and Water

The evidence was to the effect that Mr Hutton had not taken any food or water during his time in custody. Similarly there was evidence that this wasn't uncommon in persons in custody. By the same token any custody such as Mr Hutton could ask for water or food. There would have been an opportunity for Mr Hutton to ask at any of the checks or by pressing his cell buzzer and then making a request.

There was some questioning to the effect that Mr Hutton may have been dehydrated and that this in turn may have been a factor in his death.

However this was not a proposition accepted by Dr Sadler. He said that at the post mortem there was 100mls of clear urine in Mr Hutton's bladder. This did not suggest dehydration, which might have been the position had the urine been dark and concentrated.

Staffing Levels

Linda Peddie, a now retired PCSO, was on the shift starting at 7am. She claimed that staff were so busy they were "running around like headless chickens." She suggested that following an earlier FAI extra staff had been allocated but that as they had left, they had not been replaced. There had therefore been staff cutbacks. She accepted, with some degree of reluctance, that staff could approach the Sergeant and ask for extra assistance. It was not put to any of the Custody Sergeants, either that there were insufficient staff on duty or that that they had failed to assess the staff required and obtain extra assistance. As noted above Sergeant Taylor described the situation as being a normal weekend.

No evidence was led in respect of numbers in custody and/or staff levels over any period of time, analysis of custody officers' duties or how such duties might or might not impact any part of the system such as checks.

Chief Inspector Milne had actual previous experience of being a member of custody staff as well as being an expert on custody matters generally. He explained how custody operated in terms of obtaining additional cover and how in his experience Supervisors took steps as and when necessary to ensure there were sufficient staff.

Returning to the relevant Subsections of the 2016 Act:

Section 26(2)(e)

Any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.

Findings under this Subsection must meet both criteria, ie. a precaution which could have been reasonably taken **and** which might have realistically resulted in the death being avoided.

It is submitted there were no such precautions.

There was no evidence to support any finding in terms of this subsection.

A proper risk assessment was carried out. Mr Hutton's circumstances were discussed on the handovers. Dr Henderson had no concerns when carrying out the impairment test. Checks were carried out and responses obtained. The Nurse Janine Watson was satisfied

with Mr Hutton's responses. In respect of food and in particular drink, Dr Sadler did not consider dehydration was a factor in the death.

There was a time gap of 55 minutes between the 12 noon check and Mr Hutton being discovered at 1255. There was no evidence to suggest that there would have been a different outcome had a check been carried out at 1230. Dr Sadler advised that in his view death could have taken place over a period of time. On the other hand, he said that Mr Hutton could have been roused but within minutes gone into a coma and died.

There was insufficient evidence to consider that staffing levels were inadequate.

Section 26(2)(f)

Any defects in the system of working which contributed to the death or any accident resulting in the death.

It is submitted that there was no defect in the system of working. Police Scotland had a suitable and sufficient system, from an initial risk assessment through a checking procedure and the ability to reassess as necessary. This included provision to call on the custody nurse or to have a custody taken to hospital.

Any failures there may have been, involved not fully implementing the system of work in place, a different matter from a system defect.

Section 26(2)(g)

Any other facts which are relevant to the circumstances of the death.

There was a query over the methadone level in Mr Hutton's blood. Dr Sadler considered it was higher than he might have expected. On the other hand, drug levels measured from a post mortem were not reliable. With the complicating possibility of a cardiac problem and given the drugs taken by Mr Hutton, it is impossible to say exactly what Mr Hutton had taken and when.

Any death is a tragedy for the family. On behalf of Police Scotland I would like to offer our condolences to the family.

James A. F. Reid

Solicitor for The Chief Constable/Police Service of Scotland

Reid Cooper Solicitors

18 November 2019

Submission on behalf of Tayside Health Board

1. Determination

Section 26 of the Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 sets out the matters on which a determination must be made. My invitation to the Court is that only mandatory formal findings be made in terms of sections 26 (a) and (c) of the 2016 Act, determining where and when the death occurred and the cause of death. Based on the evidence led the Court is invited to make the following determination:

(a) When and where the death occurred

Mark Patrick Hutton was pronounced life extinct at 13.29 hours on 5 March 2016 within cell 8 at Police Scotland, Tayside Divisional Headquarters, West Bell Street, Dundee, DD1 9JU.

(c) The cause or causes of the death

The cause of Mark Patrick Hutton's death was acute and chronic adverse effects of Methadone, Diazepam and Etizolam and possible inherited cardiac abnormality.

2. Submission - background

[1] This is a mandatory Fatal Accident Inquiry into the death of Mark Patrick Hutton who at the time of his death on 5 March 2016 was in the legal custody of the Police Service of Scotland, at Tayside Divisional Headquarters, West Bell Street, Dundee, DD1

9JU. Initially, evidence was led over three days on 24, 26 and 27 June 2019. The Inquiry was continued to a further two days of evidence heard on 28 and 29 October 2019.

[2] The evidence led before the inquiry has been focussed on [i] how Mark Patrick Hutton presented in the hours preceding his death; and [ii] the observation checks made on Mark Patrick Hutton whilst he was in legal custody.

This submission addresses the following

1. The presentation of Mark Patrick Hutton [the deceased]
2. The contact between the deceased and nurse Janine Watson
3. The causes of death as identified by Dr Sadler

3. The presentation of the deceased

3.1 Roadside. It is agreed that the deceased was reported to police for riding his moped erratically shortly before 21.50 hours on 4 March 2016. When stopped by police constables he was observed to be under the influence of either drink or drugs. It is agreed that the deceased was able to stand unaided and was not staggering about or being held up by police constables. The deceased failed an impairment test carried out at the roadside. A roadside breath test was negative for alcohol, allowing an inference to be drawn that the deceased was under the influence of drugs. The deceased was detained on suspicion of a contravention of Section 4 of the Road Traffic Act 1988.

3.2 Custody suite charge bar. The deceased was taken to the Tayside Headquarters of Police Scotland at Dundee. During the journey the deceased was described by constable Cook who travelled with him as lucid, with nothing in his demeanour giving rise to any concern. CCTV viewed during the Inquiry, confirmed that on entering the custody suite and at the charge bar, the deceased was able to walk and stand unaided, and that he understood and responded appropriately to questions put to him.

3.3 Impairment test . As the deceased had failed the roadside test and been charged with a contravention of Section 4 of the Road Traffic Act, Police Scotland arranged for him to be examined by Force Medical Examiner Dr Bruce Henderson. The examination was not instructed for any medical reason, or by concern for the deceased's welfare. The deceased consented to being examined at 22.45 hours on 4 March 2016. At around 23.09 hours same date, Dr Henderson attended and carried out a number of tests to confirm whether the deceased was impaired due to the consumption of drugs. During the test Dr Henderson asked the deceased a series of questions. The deceased was able to provide a medical history to Dr Henderson and was aware of the circumstances leading to his detention. The Dr carried out a number of physical tests and the deceased was found to be impaired. Dr Henderson had no concerns about the deceased's health and saw nothing to indicate that the deceased should be transferred to hospital. Dr Henderson saw nothing in the deceased's demeanour that caused him concern. Having completed the impairment examination Dr Henderson had no further involvement with the deceased's care or treatment. Dr Henderson recorded his findings in medical records being Crown production 27.

4. Contact between the deceased and Nurse Janine Watson

4.1 The nursing handover

The impairment assessment by Dr Henderson was carried out in the presence of nurse Nathan Vohra. At 00.08 hours on 5 March 2016 nurse Vohra made a note in the medical records that the deceased reported that he used eye drops. It is recorded that the bottle of liquid in the deceased's possession had a torn label and could not be used. At the nursing handover to Registered Nurse Janine Watson at around 07.00 hours on 5 March, nurse Vohra discussed the medical issues arising from individuals in custody who had been seen by medical staff overnight. He made nurse Watson aware that the deceased used eye drops.

4.2 Nurse Watson's actions in respect of the prescription

Nurse Watson, in her evidence confirmed that she had access to the deceased's medical notes. She confirmed that she followed up on the deceased's prescribed eye drops. She confirmed that her only concerns were about the deceased's eye drops not his demeanour. She confirmed that she went to see the deceased. There is evidence that the purpose for which nurse Watson saw the deceased was to ask him about his prescription for eye drops. This is confirmed in her police statement provided on 5 March 2016, in which she states, "About quarter to ten (09.45 hours same date) I needed to speak to Mark about the eyedrops".

There is a conflict within the evidence, as to whether nurse Watson attended to see the deceased to discuss his eye drops, or in response to Police Custody and Security Officer [PCSO] Brian Conway expressing concerns about the deceased. Nurse Watson could not recall any specific concerns raised by PCSO Conway. Nurse Watson in cross examination accepted that she may be in error about having been asked to attend due to concerns expressed by PCSO Conway. It is submitted that when all the evidence is considered it supports a finding that nurse Watson attended at Cell 8 to seek clarification from the deceased about his prescribed eye drops. The CCTV evidence confirms that there was no opportunity for PCSO Conway to visit the nursing station and speak to nurse Watson between his assessment of the deceased at around 09.25 hours and the nurse's visit to the deceased's cell. PCSO Conway in evidence was clear that at no time did he have any concerns about the deceased, nor did he ask nurse Watson to examine the deceased until around 12.55 hours same date.

4.3 Nurse Watson's engagement with the deceased at 09.27 hours

At around 9.27 hours on 5 March 2016 nurse Watson entered cell 8. On entering the cell, she crouched beside the deceased who was lying on his bunk. She confirmed that it was usual for prisoners to remain in their bunk and for her to crouch down as a normal part of her communication with them. She asked him which chemist prescribed his medication. He responded Boots. She asked which branch of Boots, and he responded saying Happy Hillocks. This is an accurate response as it is agreed evidence that Happy Hillock shopping centre is where he got his prescription. Nurse Watson

confirmed that the deceased was open eyed when he spoke and was talking to her directly. Given his clear answers to her questions, nurse Watson confirmed that she had no concerns about the deceased's demeanour.

Following her visit to see the deceased, at 09.40 hours nurse Watson made an entry in the deceased's medical records accidentally using the login details of her colleague Diane Gallazzi. The entry confirmed that nurse Watson had phoned Boots at Happy Hillock about the deceased's medication, but no eye drops were in stock. In this entry she recorded that the deceased was under the influence of illicit substances. In evidence she clarified that he hadn't been obviously under the influence when she had spoken to him, but she was aware that he was detained having been under the influence of illicit substances.

4.4 PCSO Conway

PCSO Conway in his evidence confirmed that the only time he had any concerns about the deceased's demeanour was at around 12.55 hours on 5 March 2016. He did not depart from that position despite extensive cross examination. He entered the cell at around that time and left seconds later. There was no urgency in his manner as he left the cell, he did not activate the emergency alarm located in the corridor outside the cell. He attended at the nursing station and asked nurse Watson to come and see the deceased; he did not indicate an emergency to the nurse. Nurse Watson attended the deceased taking her blue, non-emergency medical bag. On entering cell 8 she

immediately realised she was dealing with a medical emergency. The deceased was apparently not breathing, was cold and his lips were cyanosed. She immediately told PCSO Conway to bring her emergency bag containing the defibrillator and oxygen. As he left, she immediately hit the strap alarm in the corridor to summon assistance. Given the deceased's heart had stopped she began cardio-pulmonary resuscitation [CPR] which replicates the action of the heart, by pumping blood to vital organs. It is agreed that efforts to resuscitate the deceased continued until 13.06 hours when paramedics took over. All efforts to resuscitate the deceased were unsuccessful.

5. Cause of death

Dr Sadler explained that cocktails of drugs, such as those present in the deceased's toxicology results, have a more potent effect in combination than the sum of the anticipated effect where drugs are taken individually. The drugs consumed depress respiratory effort. The methadone levels found in the deceased's toxicology results were consistent with fatal levels. The methadone level found was not consistent with the deceased having only ingested his prescribed methadone, but one explanation for that is that samples taken in death can produce spurious results. It was not possible for Dr Sadler to say whether the deceased had taken non-prescribed methadone. It is submitted that given the deceased's obvious impairment when he was spoken to by police some 10 -13 hours after he had taken his methadone prescription, it is open to the Court to infer that the deceased had ingested non-prescription methadone after taking his prescribed methadone on 4 March 2016. In 2015 the deceased was diagnosed with

a potential heart aspiration. This can cause the heart to stop without warning. It was impossible for Dr Sadler to say whether the deceased had succumbed to the fatal level of drugs he had consumed causing respiratory failure, or whether he had died as a result of his heart stopping suddenly.

6. Conclusion

Tayside Health Board offer condolences to the family and friends of Mark Patrick Hutton and to all those affected by his death. The Court is invited to find that in respect of the involvement of the Board, there were no precautions which could reasonably have been taken, which had they been taken, might realistically have resulted in the death being avoided. In so far as relates to the involvement of the Board, there were no defects in any system of working which contributed to the death.

Ann MacNeill

Advocate

12 November 2019