

SHERIFFDOM OF TAYSIDE, CENTRAL & FIFE AT PERTH

DETERMINATION

by

Sheriff Simon Collins QC

in an inquiry under s.1(1)(a)(ii) of the
Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

into the death of

JAMES BIRNIE MILNE

Perth, 28 September 2015

The Sheriff, having considered all the evidence adduced, **DETERMINES**, in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, s.6(1):

- (a) That the late James Birnie Milne, born 30 December 1958, who ordinarily resided at Kinloch Rannoch, died at 04.00 hours on 11 May 2013, within the Intensive Care Unit, Perth Royal Infirmary, Taymount Terrace, Perth, PH1 1NX;
- (b) That the cause of death was a cardiac arrest induced by high alcohol concentration and respiratory depression, against a background of chronic alcoholism and atherosclerotic coronary heart disease;
- (c) That there were no reasonable precautions whereby the death might have been avoided;
- (d) That there was no defect in any system of working which contributed to the death; and
- (e) That other facts relevant to the circumstances of the death are as found and further discussed below.

FINDINGS IN FACT:

Background

1. The deceased is James Birnie Milne, whose date of birth was 30 December 1958

(hereafter “the deceased”). At the time of his death he resided with his brother Ewan Milne at Kinloch Rannoch.

2. The deceased had been a chronic alcoholic since at least 1994. As a result he suffered from Korsakoff’s Psychosis, a syndrome which can affect memory, lead to confabulation of information, and alteration of perception and general behaviour. The deceased had made multiple attempts to address his alcohol dependency, all of which had been unsuccessful.
3. The deceased rarely attended his GP in the last five years of his life. However he was seen by his GP on 16 July 2012 and noted to be drinking three and a half litres of whisky and ten cans of lager per week. He was prescribed vitamins and referred to Tayside alcohol services, but failed to attend. He spoke to his GP on only one further occasion, on 10 December 2012, when it was recorded that he was still drinking heavily and not willing to engage in a detox. He was again encouraged to attend with alcohol services but did not do so.
4. Apart from his alcoholism, the deceased was not known to his GP or health services to have any other significant ongoing medical conditions.
5. On 18 February 2013, and again on 4 March 2013, the deceased was detained by the police for being drunk and incapable. On both occasions he was taken to Perth Police Office, admitted into custody, held overnight, and released the following day. CCTV footage from Perth Police Office is available in relation to both admissions.
6. The CCTV footage from 18 February 2013 shows the deceased walking unsteadily from a police vehicle, each of his arms held by a police officer. On entry to the building he was taken to the cell area in order that he could use a cell toilet to relieve himself. He then walked to and was helped to sit on a bench in a detention room. He then sat, unsupported, for more than 10 minutes, to await being processed at the charge bar. He appeared to speak with the police officers on occasions during this time. He was then helped to his feet and walked to the charge bar, again with a police officer holding each of his arms. He was able to stand at the charge bar for around 12 minutes while being processed, with the officers still holding his arms, steadying and supporting him. He then walked to the cell, again with two officers’ assistance as before. One of the detaining officers on this occasion was PC Mark Donnan.
7. The CCTV footage from 4 March 2013 shows the deceased being taken from a

police vehicle and placed on the ground by the two arresting officers. They then dragged him to the charge bar by the upper arms, with his feet dragging on the ground. He was questioned by the custody sergeant, while slumped on the floor in front of the charge bar. He replied to questions, including giving his name, date of birth, and stating that he was an alcoholic. He then said that he needed to 'pee'. The officers were then told to take the deceased through to a cell, and with the sergeant's permission they dragged him there. Wet streaks on the floor indicated that he had urinated on himself, but his wet clothing was not removed and he was not placed in dry/clean clothing. He was not examined by any medical personnel.

Police attendance at Kinloch Rannoch, 7 May 2013

8. At around 14.40 hours on 7 May 2013 PCs David Guest and Daniela Mackay were on duty at Pitlochry Police Office. They received a radio message to attend at a disturbance at the deceased's house in Kinloch Rannoch, it being reported that he and his brother were engaged in a fight. They responded to this request and drove to Kinloch Rannoch, arriving at the house at about 15.17 hours.
9. Shortly after responding to the initial message PCs Guest and Mackay had requested the assistance of another police unit. PCs Kevin Heafey and Mark Donnan, then stationed in Perth, responded to this request. PC Heafey was the senior officer, having more than 20 years service, while PC Donnan was still a probationer. They too drove to Kinloch Rannoch. From Perth to Kinloch Rannoch is a distance of around 40 miles. The officers put their blue light on in order to speed the journey, but it still took them nearly an hour, and they did not arrive at the deceased's house until about 15.40 hours. While on route they heard PC Guest radio for an ambulance to attend also.
10. On arrival PCs Heafey and Donnan were advised by PC Guest of the circumstances. There were signs of a violent struggle having taken place in the garden ground around the house. The deceased and his brother Ewan were both present. Both had been arrested by PCs Guest and Mackay for a breach of the peace.
11. Ewan Milne was observed by PC Heafey to have a significant injury to his forehead. He also had blood on his head, face and clothing. He was sitting quietly at the side door to the property on a step. He appeared heavily intoxicated.

There was an empty half bottle of whisky beside him, and also a full bottle of whisky.

12. PC Heafey went inside the property with PC Donnan and saw the deceased lying on a sofa in the sitting room. PC Donnan recognised him from their previous contact on 18 February 2013. He was fully dressed, but was covered with a duvet. He had significant grazing and scratching to the top of his head. There was dry blood on his clothing, head and hands. PC Heafey spoke to the deceased and asked him if he was OK. The deceased opened his eyes and was able to reply. His speech was slurred and slow, and he smelled of alcohol. He appeared heavily intoxicated. PC Heafey was satisfied that the deceased was aware of the officers' presence, and his condition did not give him undue cause for concern.
13. It is unclear precisely how much alcohol the deceased consumed on 7 May 2013, or precisely when he stopped drinking during that day. However he cannot have consumed any more alcohol after 15.17 hours, the time when PCs Guest and Mackay arrived at the house.
14. Given the injury to Ewan Milne's forehead, the officers decided that he should be taken to hospital for assessment. In relation to the deceased, it was decided that PCs Heafey and Donnan would take him to Perth police station. The deceased was informed of this. He said that he did not want to go to Perth. He was asked to stand and go to the police vehicle. He refused. He was told that if he did not cooperate he would be carried out to the vehicle if necessary. He then invited the officers to carry him and held out his arms. PCs Guest and Donnan then each took an arm and helped the deceased out of the house.
15. At no time during this process was the deceased abusive to the officers. At no time did he struggle with them. Rather he expressed opposition to what the officers wanted him to do and offered passive resistance only. There were no grounds to suggest that he was resisting arrest. He was not actively cooperative, but nor was he actively troublesome. He was not handcuffed.
16. Given the deceased's intoxicated condition, and the circumstances which had led to the police's attendance, it would not have been in his best interests nor the public interest for the police officers to have taken no action and left him alone at his home.
17. PCs Heafey and Donnan's vehicle was a police van with a small secure cell area for prisoners at the back, with benches on either side. This area is accessed by

doors to the rear of the vehicle, and a further caged door within. The deceased was assisted into the cell area by the officers. He declined to sit on the benches, saying that they were too hard. Instead he sat on the floor between the benches.

18. PCs Guest and Mackay remained at the house at Kinloch Rannoch with Ewan Milne, to await the arrival of the ambulance, and to escort him to hospital.
19. PCs Heafey and Donnan left Kinloch Rannoch with the deceased at around 1550 hours. PC Heafey drove the van. PC Donnan sat in the passenger seat and maintained observation of the deceased in the rear area through a viewing window. The officers did not put their blue light on in order to speed their journey to Perth as they did not see the need to do so.
20. At around 16.20 hours PC Heafey stopped the van in a layby on the A9. PC Donnan got out of the van and went to the back to check on the deceased. He opened the cell door and observed that the deceased was asleep, still sitting on the floor. He shook him awake and spoke to him. He asked if he was OK. The deceased opened his eyes and made an incoherent response. Satisfied with this the officers continued with the journey. The deceased was not asked whether he needed to relieve himself, nor was he afforded the opportunity to do so.
21. In the course of the journey PC Donnan completed a Fixed Penalty Notice in relation to the deceased, narrating a charge of common law breach of the peace, for engaging in a stand up fight to the alarm and annoyance of the lieges. This was not served on the deceased as he was not in a fit state to receive it.

Admission of the deceased to custody at Perth Police Office

22. PCs Heafey and Donnan arrived with the deceased at Perth Police Office at about 17.00 hours. PC Heafey drove the van into the secure compound and he and PC Donnan went to the charge bar to speak to the custody sergeant on duty, Sergeant Michael Assenti. Sgt. Assenti was at that time a very experienced police officer and custody sergeant with many years' service. The deceased remained in the back of the van. PC Heafey learned that another prisoner was being processed and that there would therefore be a delay in processing the deceased.
23. PC Donnan returned to the van at about 17.05 hours and opened the rear doors of the vehicle. The deceased was still within the cell area, behind the secure caged door, and was observed to still be sitting on the floor between the benches, apparently asleep. The rear doors were left open, and the deceased remained in

the cell area of the stationary vehicle.

24. Around 30 minutes passed, during which time PCs Donnan and Heafey checked on the deceased on a few occasions by briefly looking into the cell area through the caged door and speaking to him. He was asleep or barely conscious throughout. At some point during this period the deceased urinated on himself through his clothing. He had by now been detained in the cell in the van for approximately one hour and forty minutes without a break.
25. By around 17.31 hours the previous prisoner had been processed through the charge bar and the officers were ready to process the deceased. At 17.34 hours PC Heafey returned to the van and opened the cage door. He noticed that the deceased had urinated on himself. He was still sitting on the floor. PC Heafey spoke to the deceased and got some basic verbal recognition from him, but not much more. He was conscious, but his condition of intoxication appeared to PC Heafey to have worsened in the time since they had left Kinloch Rannoch.
26. PC Heafey was concerned that the deceased might not be able to walk unaided to the charge bar given his condition. He was aware that within Perth police station there was an “ambu-chair”, a lightweight wheeled chair, without arms, generally used to move persons to and from an ambulance where that person has a medical disability and/or is unable to walk. He went to find the ambu-chair and to report to Sgt. Assenti.
27. At about 17.36 hours the following exchange, captured on CCTV, took place between PC Heafey and Sgt. Assenti at or near the charge bar:

H: “Is that seat available?”

A: “Mm?”

H: “Seat. He’s in the van and he’s pished and he’s pished himself.”

A: “Fuck’s sake.”

H: “Ah know”.

A: “Mind you he’s been sitting in that van for fuckin’ ages”.

H: “Absolutely right, aye, absolutely.”

A: “Do you know where the seat is Kev”?

Thereafter PC Heafey went to get the ambu-chair and Sgt Assenti went out to the van, where he observed and spoke to the deceased.

A: “What a state to get into. Eh? Jimmy. We’re trying to help you. Come on. Lean forward. Up!”

The deceased was able to say one or two words but was unable to get himself up and out of the van or to walk to the charge bar. Sgt. Assenti then went back into

the police station.

28. Having found the ambu-chair PC Heafey took it out to the van. He and PC Donnan then lifted the deceased out of the van and onto the chair. The deceased was not able to do this for himself. He was however able to sit in the chair outside the van unaided for a couple of minutes, albeit that his head was back or lolling from side to side, and on one occasion he appeared to almost fall out of the chair.
29. At around 17.39 hours Sgt. Assenti returned to where the deceased was sitting. PCs Heafey and Donnan were also present. Sgt. Assenti stood over the deceased and spoke to him in an increasingly robust manner, initially trying to encourage him to stand up and walk into the police station, and then raising his voice and ordering him to do so:

A: "Jimmy, come on. You're in some state man aren't ye, eh? Some state."

...

"Jimmy. Jimmy. Look at me. Look at me."

...

"Jimmy! Wake up. Come on, on your feet. Can you stand up, let's go. Up! Stand up! Up, up, up!"

...

"Come on, stand up! Can ye stand up? Come on! Come on! Stand up!"

All this was unsuccessful. The deceased was unable to stand or walk. He was then wheeled the short distance from the van to the charge bar in the ambu-chair, PC Heafey pulling the chair backwards and PC Donnan attending on or holding the deceased to prevent him from falling out.

30. As the deceased was being brought into the charge bar Sgt. Assenti briefly discussed with the other officers present, including Police Security and Custody Officer Alison Gordon and PC Heafey, the circumstances which had led to the deceased being arrested and brought to Perth police station:

G: "What's he in for?"

A: "Jesus Christ. Breach of the peace."

...

A: "This happened in the street?"

H: "Outside in his garden"

...

A: "Imagine getting into a state like that. Its unbelievable."

G: "First day of good weather as well."

A: "Ah know."

H: "He does this all the time."

A: "Eh?"

H: "He does this all the time. These two."

...

A: "Just the two of them stay on their own?"

H: "Yeah."

Neither Sgt. Assenti nor PC Heafey had previously had contact with the deceased (Sgt. Assenti had not been the custody sergeant when the deceased had been brought to Perth on either 18 February 2013 or 4 March 2013). PC Heafey must have got the information that 'he does this all the time' from PCs Guest or Donnan. PC Heafey did not mention to Sgt Assenti that the deceased's state of sobriety appeared to have noticeably worsened in the period since leaving Kinloch Rannoch and arriving at Perth, even though by then he had consumed no alcohol for a period of nearly two and a half hours.

31. The deceased arrived at the charge bar at around 17.42 hours. He was there for only about two minutes, during which time he was apparently conscious, with his eyes open, and was able to continue to sit in the ambu-chair unaided. Occasionally he moved his head or arms around. He was questioned by Sgt. Assenti from behind the charge bar counter as follows:

A: "Right. James"

JM: "Yes"

A: "Tell me your name."

JM: [no answer]

A: "Tell me your name."

JM [no answer]

A: "Go on."

JM: [mumbles incoherently]

Sgt. Assenti then went round the counter and stood over the deceased as he sat in ambu-chair:

A: "Eh? Tell me your name. Come on."

JM: [no answer]

A: "James what?"

JM: [mumbles incoherently]

The tone of this questioning was direct and robust, but not improper.

32. In the light of the deceased's failure to give any meaningful response Sgt. Assenti did not question him further, but instead decided to admit him to custody. This was a decision for him alone to make, as custody sergeant. He said:

A: "Right. Straight through. We'll be here all night trying to get any sense out of him. Straight through."

The deceased was then wheeled from the charge bar to be detained within the cell

area of the police station. Meantime there was a short exchange between Sgt. Assenti and PC Heafey:

A: "Kev, listen Kev because..."
H: "We don't know anything."
A: "We don't know anything."
H: "Aye"
A: "We'll just suit him and boot him and a full search."
H: "Okay".

By 'suit him and boot him' was meant to strip him of his own clothing and place him in protective custody clothing.

33. PC Heafey had previous experience of seeing persons in similarly intoxicated conditions to the deceased being taken into police custody. He was not surprised that Sgt. Assenti had admitted the deceased to custody. He had never previously taken a detained person to hospital simply on account of intoxication. PC Donnan, then a probationer, also did not have any concerns and did not think that the deceased should be going to hospital. They both acknowledged that ultimately this was a decision for Sgt. Assenti, as custody sergeant, whose judgment and experience they respected.

Risk assessment of the deceased on admission to custody

34. Having decided to admit the deceased to custody and place him in a cell Sgt. Assenti discussed the completion of the relevant custody and risk assessment forms with PCSO Gordon. She queried whether the deceased had had any visible injuries and Sgt Assenti reminded her that he did have:

A: "Yeah. There was... He's got grazing, grazing to the head... But ah mean he disnae... He's conscious. He disnae have any, he disnae look as if he's suffering fae a internal head injury."

Sgt. Assenti did not consider that any medical attention was required for the deceased.

35. A custody risk assessment checklist form relative to the deceased is lodged as Crown Production 9. It was completed by more than one person, in handwriting, and is timed and dated 17.00 hours. The first page details the deceased's personal details, identifies the arresting officers, and provides a brief outline of the events at Kinloch Rannoch. Criminal History Scotland and Police National Computer reference checks are referred to. No previous convictions are noted, but a pending

case against the deceased under section 6 of the Road Traffic Act 1988 is referred to (drink driving). There are no “warning signals” recorded for the deceased such as, for example, a history of violence or use of weapons. On the second page a question “Injured Y/N” has been circled “Y” followed by “graze to forehead”. A question “Under influence drink/drugs” has the entry “Drink”.

36. Crown Production 10 contains four pages of computer generated pro-forma documents forming part of the risk assessment of the deceased. These are typewritten and were completed by DCSO Gordon. The first page notes that the risk assessment “process commenced” at 17.40 hours, and identifies Sgt. Assenti as the assessing officer at 1746 hours. It records the deceased’s “current vulnerability” as “high” but “no” special risk. “High risk” was selected by Sgt. Assenti due to the level of the deceased’s state of intoxication. “Frequency of [cell] visits” is recorded as “30 minutes”. The second page of the document repeats this information but contains a typewritten narrative in effect dictated by Sgt. Assenti and entered by PSCO Gordon:

“Under influence of alcohol. Unable to answer questions at charge bar.
Straight to cell from charge bar. Full suit and search.”

In relation to “Special Risk Information” is recorded “Special risk [no] Risk Markers Known [No] Nothing to add.” On the second page there is a checklist of “At risk categories”. Although one of these categories is “known drug/alcohol dependency”, and another is “physical injury”, neither has been ticked as present. There is also a “Prisoner medical information” section, for recording whether medical information has been requested, or a doctor called, the reasons for such actions, the date and time of any medical attendance and the result of any examination. These sections are all blank.

37. Finally, on the fourth page of this document, under the heading “Self Risk Assessment”, is a series of 12 questions. The recording officer is again noted as Sgt. Assenti. The questions include the following:

- “1. Are you suffering from any injury?
2. Are you suffering from any medical condition?
3. Are you taking any medication?
- ...
5. Do you suffer from any form of alcohol dependency?
- ...
7. Have you consumed any alcohol in the last 24 hours and if so what type, how much, and when?

8. Do you suffer from, or have you ever suffered from any form of mental illness or disorder?
9. Have you ever committed any act of self harm or attempted suicide?
10. Do you have any other relevant information relating to your personal care and welfare whilst in custody?
- ...

In relation to all 12 questions the words “Response: Non Co-operation – Non Co-operation” has been typed by way of answer. This represents one of the available responses from a drop down menu on the relevant computer. It does not accurately describe the reasons for the deceased’s failure to answer. There is no drop down menu available to reflect the actual situation. This was as recorded on the previous page of the form, that is, that none of the questions was ever asked as the deceased would have been unable to answer them due to his being heavily under the influence of alcohol.

38. By the time that Sgt. Assenti made the decision to admit the deceased to custody it was or ought to have been obvious to him that he was, through apparent severe intoxication, unable to walk to the charge bar, and at times barely able to support himself on the ambu-chair. It was or ought to have been obvious that the deceased, although conscious, was unable to give meaningful responses to questioning, or to provide any information relevant to his circumstances or his fitness to be detained. It was also clear that the deceased had been involved in a violent physical altercation earlier in the day as a result of which he had a visible, if apparently superficial, head injury. Had the information been asked of or provided by PC Heafey, it should also have been known that the deceased’s condition of intoxication had worsened since his arrest, even though that had been more than two and a half hours earlier.
39. Given the deceased’s condition at the charge bar it was not reasonably open to Sgt. Assenti to simply release him onto the street at this time. This would not have been in the deceased’s best interests, nor in the public interest.

Hospital services

40. In the event that a custody sergeant at Perth Police Office at the relevant time decided that a prisoner at the charge bar required medical assessment or treatment such that they should not be admitted to custody, he or she could phone for an ambulance and have the person taken to the accident and emergency department

at Perth Royal Infirmary. This was regularly done, and had been done in the past by Sgt. Assenti.

41. Hospital health services, including the accident and emergency department at Perth Royal Infirmary, do not welcome being sent by the police persons whose only apparent problem is acute alcohol intoxication. This was well known to custody officers, including Sgt. Assenti. This is because there is no specific medical treatment for simple alcohol intoxication, and because, in the majority of cases, what is required is simply a safe and secure environment, where the person can be given a bed, put in the recovery position, and left to sleep and sober up while being regularly monitored. If an intoxicated person is admitted to hospital they will likely be placed in a normal ward for this purpose. They will not routinely be connected to a heart monitor.
42. If an intoxicated person is sent to hospital by the custody officer at Perth, however, experience suggests that after initial assessment they are often returned to police custody, either immediately, or when they have sobered up, depending on the circumstances.

43.

Police Custody Nurse services

44. In around 2009 Tayside Police set up, in conjunction with local health services, what was then a pilot scheme system of Police Custody Nurses. This service, based in Dundee, was in May 2013 available on a 24/7 basis to police custody sergeants in Tayside. Its general purpose was to triage the needs of prisoners coming into police custody. Detailed guidance to officers of Tayside Police regarding this service is set out in a document lodged as Crown Production 37. A Service Level Agreement between Tayside Police and NHS Tayside is lodged as Crown Production 38. Although this was never formally signed off by the Chief Constable it nevertheless describes the level of service in fact provided. NHS Tayside's standard operating procedure for the service is lodged as Crown Productions 39 and 40.
45. By phoning the PC Nurse custody sergeants such as Sgt. Assenti could ask, in particular, (i) for general medical advice concerning a prisoner, (ii) for a check of his or her medical records to be made insofar as those were accessible to the Nurse, and/or (iii) for the Nurse to attend at the police office in order to examine and assess a prisoner. A decision whether to attend at a police office was

ultimately a decision for the Nurse, albeit one made in discussion with the custody sergeant. However travelling to Perth or Arbroath police offices from Dundee was not regarded by the nurses as onerous, but as simply part of the job, and was regularly done.

Alcohol Treatment Centres ('Drunk Tanks')

46. There were no Alcohol Treatment Centres ('Drunk Tanks') available within Tayside, such as might have provided a suitable, safe and secure environment for holding drunk and incapable persons, as an alternative to police custody or referral to hospital.

The events in Cell 2, Perth Police Office

47. At around 17.45 hours the deceased was taken from the charge bar to Cell 2 within the police station by PCs Heafey and Donnan, assisted by a PC David Rice. He was still in the ambu-chair. Cell 2 has a low set bed, such that if a prisoner should roll off it he is unlikely to be injured. There the deceased was stripped of his clothing, searched, placed on a mattress in the recovery position, and covered with a blanket. He continued to be conscious but passively uncooperative. His clothes were placed in a bag. A two piece harm prevention suit was obtained, but the deceased was not dressed in it. The suit was left in the cell. The deceased was left naked under the blanket.
48. On Sgt. Assenti's instructions the deceased was to be checked at half hourly intervals. To make an intoxicated prisoner subject to such frequency of checks is standard for persons admitted to custody under the influence of alcohol. It is unlikely that a person admitted to a hospital ward after transfer from police custody, solely due to being in an intoxicated state, would be checked more frequently than every 30 minutes. Had the deceased been taken to and admitted to hospital, rather than admitted to custody by Sgt. Assenti, it is unlikely that he would have been checked more frequently than every 30 minutes.
49. At 18.00 hours PCSO Laura Kernan came on duty and checked on the deceased at Cell 2. She pulled down the door hatch, saw him still lying in the recovery position, and shouted to see if he was all right. He lifted his head off the mattress, looked at PCSO Kernan and said "Argh". She took this to be a positive response to her question - in that he was trying to answer her but was still intoxicated - and

noted it on the cell sheet (now part of Crown Production 10).

50. At 18.30 PCSO Kernan again checked on the deceased, this time with Sgt Assenti. They entered the cell. The deceased was still lying in the same position as previously. Initially they got no verbal response from him, but shook him and pinched his ear and he said “Aye”. Again this was noted on the cell sheet.
51. At around 18.35 hours Sgt. Assenti telephoned the on call NHS Police Custody Nurse, Jacqueline Reid. Nurse Reid is a senior nurse, with over 30 years’ experience. Sgt. Assenti phoned with a view to finding out if there was a record of the deceased having any underlying medical conditions in his previous history. This was because the deceased had been unable to answer the relevant risk assessment questions at the charge bar. Sgt. Assenti told Nurse Reid that the deceased had been conscious but extremely drunk and could not give appropriate information to him, but that he had no other concerns about him. Nurse Reid was content to accept Sgt. Assenti’s judgment. She knew him to be a very experienced custody sergeant.
52. Nurse Reid was able to access some of the deceased’s medical/hospital records held digitally via a Multi Disciplinary System. She was able to ascertain, and advised Sgt. Assenti (see Crown Production 5) of two previous entries from Tayside Alcohol Problem Services, neither of which the deceased had attended. Nothing else was documented. The clinical portal showed nothing of significance other than routine investigations and blood tests and a history of alcohol abuse. No long term conditions were noticed. There was in particular no medical record to suggest that the deceased was otherwise at particular risk of having a heart attack. She was able to ascertain and advise that either the deceased kept good health other than his alcohol issues, or that due to these issues he did not routinely attend his GP for any problems he might experience. In the absence of other information from Sgt. Assenti, Nurse Reid was not concerned by the situation or by his handling of the situation.
53. Sgt. Assenti did not however tell Nurse Reid about the deceased’s head injury in the course of the 18.35 phone call. Had he done so she would have wanted to know more about it and the circumstances in which it had been inflicted. Had she agreed with Sgt. Assenti that the injury was superficial only, she would not have felt the need to attend at Perth Police Office to assess the deceased. It is possible that she might have advised Sgt. Assenti to increase the frequency of observation

of the deceased, perhaps to every 15 minutes. Had she considered that the deceased might have suffered a traumatic head injury, for example resulting from a fall to the pavement or kerb, she would likely have gone to Perth to assess him. She did not become aware of the deceased's head injury until a further call was made to her, by a Sgt. Dunlop, at 19.20 hours.

54. Sgt. Assenti also did not tell Nurse Reid that the deceased had been so intoxicated that he was unable to stand and had to be brought to the charge bar in a wheelchair. In Nurse Reid's opinion, then and now, such a person was not fit to be in police custody, at least without prior medical assessment. She did not ask Sgt. Assenti whether the deceased was unable to stand and walk. She would have expected him to tell her if that had been the case.
55. At 19.00 hours PCSO Kernan and Sgt. Assenti again checked on the deceased. He was still in the same position in the cell. However on this occasion it was immediately apparent from viewing him through the hatch that he was blue in the face. They entered the cell. They found that the deceased had no pulse, was not breathing, and was drooling from the mouth. Sgt. Assenti immediately instructed PCSO Kernan to call for an ambulance and for other officers to assist. Sgt. Assenti was joined in the cell by PC Gavin Smith and PCSO Gordon. A defibrillator was stored nearby in the Police Office. It was quickly brought and applied to the deceased's chest by Sgt. Assenti. It did not administer a shock, but instructed instead that CPR should be commenced. This was done, appropriately, by Sgt. Assenti and PC Smith.
56. At this point Sgt. Assenti first discovered that the deceased was wearing a dental plate, and took it out of his mouth.
57. At 19.05 hours paramedic Julie McKay and Ambulance Technician Alexander Anderson arrived at Perth Police Office in response to the call instructed by Sgt. Assenti at 19.01 hours. They immediately entered Cell 2 and took over care of the deceased from Sgt. Assenti. They found the deceased to be asystolic, that is, that there was an absence of any electrical or physical activity of the heart. They recommenced CPR and secured intravenous access. They administered adrenaline and unsuccessfully attempted to intubate.
58. At 19.25 hours the deceased's heart rhythm was noted to change to ventricular fibrillation, that is, electrical activity of the heart but without any effective muscular contraction. An electric shock was applied from the paramedics'

defibrillator, and the deceased was returned to regular heart rhythm. An oxygen mask was employed to stimulate breathing. At 19.32 hours the deceased was removed from the cell by the paramedics and taken to Perth Royal Infirmary, arriving there at around 19.35 hours. The paramedics' E-pacer record is lodged as Crown Production 9 and accurately details their attendance on and treatment of the deceased.

Perth Royal Infirmary: 7 May to 11 May 2013

59. The deceased was admitted to Accident and Emergency at Perth Royal Infirmary at around 19.39 hours on 7 May 2013. It was clear that his condition on admission was such that there was danger to his life. He was immediately examined, assessed and treated by Dr. Gareth Patton, a full time, experienced, accident and emergency specialist registrar.
60. On examination by Dr. Patton the deceased was found to be breathing spontaneously. He had an irregular cardiac rhythm. His pupils were fixed and his blood pressure very low. His consciousness was assessed as level 3 on the Glasgow Coma Scale, that is, he was unconscious. His airway was soiled and poorly maintained. External review of his scalp revealed small wounds to the right frontal parietal regions of the scalp. There was mild soft tissue swelling but no apparent fracture. There was no active haemorrhaging present.
61. Dr. Patton's initial impression, from his examination and the information available to him, was that the deceased's heart had stopped, and that for a period of time he had therefore been effectively dead. As a result his brain would not have been receiving oxygen, with a consequent risk of hypoxic brain injury. Although noting that the deceased was intoxicated, Dr. Patton did not himself check his blood alcohol level. This was because it would not have affected management of him at this point. "Stomach pumping", for example, is no longer performed.
62. The soiling present in the deceased's airway was found by Dr. Patton to be vomit. It is not possible to say whether it was a cause of the deceased's heart attack or a consequence. It could be either. In particular loss of consciousness due to a heart attack can cause loss of the gag reflex, and thus for stomach matter to enter the airway.
63. The deceased was ventilated and intubated. Intravenous access was secured. A

blood sample was taken. Adrenaline was administered. A nasogastric intubation tube was inserted. After consultation with Dr. Michael Forster, consultant anaesthetist, a CT scan was carried out in order to rule out any intracranial bleed from his external head injury. The deceased was accordingly transferred to the hospital's intensive care unit for this procedure at around 20.00 hours.

64. The CT scan of the deceased's head revealed nothing to account for the deceased's cardiac arrest. There was no sign of a stroke, of any bleeding on the brain, or of any fractures of the skull. The scan confirmed that the injuries to the deceased's head, first observed by PCs Heafey and Donnan, and later by Sgt. Assenti, were correctly assessed by them as being superficial, were in no way responsible for the cardiac arrest which he suffered, and were not a medical cause of his death.
65. Analysis of a blood sample taken from the deceased at 22.30 hours on 7 May 2013 revealed that he had a blood alcohol level of 532mg per 100 mls of blood. This is an extremely high, indeed dangerous, level of blood alcohol. It is more than six times the legal driving limit. Given that the deceased could have consumed no alcohol for more than seven hours prior to the blood sample being taken, and that he would likely have metabolised a significant amount of alcohol during that period, his blood alcohol level at the time of his detention is likely to have been significantly higher.
66. The deceased was maintained and treated in the intensive care unit, initially under the care of Dr. Forster until 08.30 on 8 May 2013, and then under the care of Dr. Yevgeniy Kossko, specialist registrar. In accordance with recognized clinical practice in such cases the deceased's body temperature was cooled. He was rewarmed on the evening of 8 to 9 May 2013. Nonetheless he remained unconscious with no improvement. His condition was monitored and he remained in the intensive care unit.
67. On 10 May 2013 a further CT scan was carried out. This showed changes to the deceased's brain consistent with hypoxia or a brain injury caused by the cardiac arrest. This damage was irreversible and inconsistent with the deceased's continuing survival. A decision was accordingly made not to resuscitate him in the event of a further cardiac arrest or respiratory failure. The deceased's relatives were informed and accepted this.
68. The deceased's condition continued to deteriorate and at 04.00 hours on 11 May

2013 his life was pronounced extinct by Dr. Kossko. He did not regain consciousness at any point during his admission to hospital.

Post mortem

69. A post mortem examination of the deceased was carried out by Drs. David Saddler and Graham Whyte on 15 May 2013. Their report is lodged as Crown Production 1 which is a true and accurate record of their findings.
70. The medical cause of death, as recorded on the deceased's death certificate, was "I.(a) Acute and Chronic Alcoholism and its Complications. II. Atherosclerotic Coronary Artery Disease."
71. As Drs. Saddler and Whyte noted at page 2 of their report, the level of blood alcohol detected in the deceased on admission to Perth Royal Infirmary (532 mg per 100mls) was very high. Although the effect that this level of blood alcohol would have on an individual varies with tolerance, levels above 450mg per 100 mls are associated with fatal depression of the brain stem and disturbances in the rhythm of the heart (cardiac arrhythmias).
72. Drs. Saddler and Whyte also found that the deceased had been suffering from atherosclerotic coronary heart disease. Specifically his coronary arteries were found to have an 80 – 90% luminal narrowing in the left anterior descending vessel, in its proximal and middle thirds, and the left circumflex artery and right coronary artery were affected by 40% luminal narrowing in their middle thirds. This was a severe and life threatening condition. It placed the deceased at greater risk of suffering a cardiac arrest, and rendered him significantly less able to survive such an event if it occurred. However there had been no evidence to suggest that the deceased had this condition prior to his death.
73. Detailed neuropathological examination of the deceased's brain revealed widespread hypoxic ischaemic injury consistent with cardiac arrest and subsequent reperfusion following resuscitation. There were also changes associated with chronic alcohol related brain damage.

Cause of death

74. The deceased had a cardiac arrest in Cell 2 at Perth Police Office shortly before 19.00 hours on 7 May 2013. He stopped breathing. Although he was resuscitated and treated in hospital for four days he had already suffered catastrophic and

irreversible hypoxic brain injury incompatible with continuing life.

75. The precise causal mechanism which led to the deceased's heart stopping remains unclear. However it is likely to have been due to a combination of high alcohol concentration, leading to depression of his respiratory system, and his underlying coronary artery disease. Thereafter the long term weakening of his brain, heart and liver due to chronic alcoholism, in combination with his coronary heart disease, are likely to have made him less resilient to the effects of the cardiac arrest, and significantly reduced his chances of recovering from it.
76. If the deceased had not been placed in a police cell at 17.45 hours on 7 May 2013, but had instead been sent to Perth Royal Infirmary, his death would not have been avoided.
77. Had he been sent to hospital, he would likely have arrived at Perth Royal Infirmary by ambulance sometime around 18.00 hours, and been assessed by medical staff as being intoxicated. Assessment of his head injury, whether visually or by CT scan would have shown that it was superficial. Checks of any available medical records would not have revealed anything beyond that available to PC Nurse Reid, that is, that he was an alcoholic but otherwise had no known long term medical conditions. In these circumstances - if not immediately returned to Perth Police Office - he would likely have been placed in a bed, in an ordinary ward, in the recovery position, to sleep and sober up. The deceased would then likely have suffered his fatal cardiac arrest in hospital rather than in Cell 2 at Perth Police Office.
78. It is likely that the deceased's cardiac arrest occurred very shortly before 19.00 hours on 7 May 2013, that is, perhaps no more than a couple of minutes prior to his being checked by PCSO Kernan and Sgt Assenti. This is because had it occurred any earlier it is unlikely that the police officers and then the paramedics could have restarted his heart as they were able to do. Without their very prompt intervention he would have died very quickly at this point.
79. Accordingly the deceased's chances of survival would not have been materially better even if he had been in hospital when he had his heart attack. On an ordinary ward in the hospital he was unlikely to have been monitored any more frequently than he was at Perth Police Office. Consequently medical staff at Perth Royal Infirmary would not have intervened any more quickly or effectively than in fact happened. Even in well equipped hospitals with appropriately trained staff, the

survival rate from cardiac asystole in conditions such as affected the deceased can be as low as 10%.

80. Had the deceased not been detained and transported to Perth Police Office by PCs Heafey and Donnan there is no reason to suppose that he would not still have suffered a cardiac arrest when he did. In this event it would have been experienced while he was at home on his own and he would likely have died there without anyone to assist him.

Police procedures and intoxicated persons: guidance and training

81. Dealing with heavily intoxicated persons is a common and longstanding issue for police officers, in Tayside as elsewhere. As at the date of the deceased's death various policy and procedural guidance materials bearing on this issue had been produced, in particular in relation to the questions of whether, and if so how, such persons should be admitted to custody at the charge bar and detained in a police cell.
82. In May 2008 Tayside Police issued *Policy & Guidance: Prisoner Care Manual* (lodged as Crown Production 24, hereafter "the *Prisoner Care Guidance*"). This was revised in March 2010. It includes the following passage, relevant for present purposes, at paragraph 13.4:

"ALCOHOL/DRUGS

Instances have occurred where prisoners presumed extremely drunk were in fact suffering from injury, illness or drug overdose, sometimes with fatal consequences.

Prisoners under the influence of alcohol/drugs should always be placed in a cell with a low platform or laid on the cell floor in the recovery position.

Prisoners suffering from alcohol/drug dependence are at serious risk in withdrawal and require medical attention..."

83. In August 2010 Tayside Police issued *Policy & Guidance: Assessment of a Prisoner's Risk and Vulnerability* (lodged as Crown Production 23, hereafter "the *Risk and Vulnerability Guidance*"). This was revised in August 2012. The *Risk and Vulnerability Guidance* was produced by Chief Inspector Gordon Milne in the wake of a large scale *Custody Review* by Tayside Police in 2010 (a copy of which is lodged as Crown Production 17), itself prompted by a number of deaths/adverse

incidents affecting persons in custody between 2007 and 2009.

84. The overall purpose of the *Risk and Vulnerability Guidance* is stated to be to inform all police officers and support staff of Tayside Police of - and to harmonise - “procedures to be followed to ensure the proper care and welfare of prisoners” (paragraph 1). It is emphasised that the power to take away a person’s liberty “will only be exercised when all other options have been considered and deemed inappropriate” (paragraph 2). The “primary concern” of all custody staff is stated to be “the preservation of life and the protection of the well being of prisoners”, and “all prisoners must be treated with care and consideration, to ensure their human, civil and legal rights are upheld.” (paragraph 5.1).
85. Central to the instruction to police officers contained in the *Risk and Vulnerability Guidance* is the need to carry out proper risk assessment of persons brought into police custody, both at the point of admission and on an ongoing basis thereafter. This requires consideration of both threats and vulnerabilities (paragraph 5.4), with known drug or alcohol abuse or dependency being a common category of vulnerability. There is particular focus on the responsibilities of the duty custody officer. He or she is required to carry out a risk assessment for every prisoner prior to him being placed in a cell or detention room (paragraph 5.5). In order to do so, it is emphasised that there must be an initial gathering and recording of all the information available, including: the circumstances leading up to and during the arrest or detention; background information and warning markers held on police information systems; answers to questions and any other information volunteered by the prisoner at the charge bar; information or observations from the arresting or escorting officers; and custody suite staff observations of the prisoner when presented at the charge bar (paragraph 5.6).
86. In connection with information to be sought from the prisoner, the duty custody officer must (paragraph 5.9):
- “...ask the prisoner all the questions contained within the Prisoner Assessment Questionnaire section of the custody record. All relevant information should be recorded as accurately as possible, with supplementary questions used whenever required...”

In connection with information to be sought from the arresting/escorting officers (paragraph 5.10):

“All staff must be aware that the custody process begins at the moment a

prisoner is arrested or detained and not at the point when they finally arrive at a PCU. For example, the behaviour of the prisoner on being traced, the level of resistance displayed, their demeanour or any comments made during the journey to the PCU may provide valuable information to the Custody Officer in determining the level of THREAT or VULNERABILITY posed by the prisoner... Arresting and escorting officers should be asked specifically on all occasions if they have provided all pertinent information to the Custody Officer.”

In connection with the observations of the prisoner at the charge bar (paragraph 5.11):

“During the time the prisoner is present at the charge-bar, the Custody Officer and custody staff will have an opportunity to observe the prisoner, including their state of alertness, attitude to their detention, general demeanour etc. This is an important part of the assessment process and should not be rushed.”

87. If it is assessed that risk and vulnerabilities are present, the *Risk and Vulnerability Guidance* requires that a care plan should be determined by the custody officer, to include the frequency of cell observations, and other interventions, for example the referral of the prisoner to the NHS Custody Nurse, or removal of the prisoner to hospital for medical assessment and treatments (paragraph 5.14). Only three levels of observation are available: general, intermittent or constant (paragraph 5.15). Intermittent observation means:

“...checked at least every 30 minutes, verbal response required every time. If no verbal response, then cell entered in an appropriate manner, prisoner to be roused and verbal response obtained.”

As is noted at paragraph 5.19, since January 2009 NHS Custody Nurses provided custody medical services to Tayside Police. Nurses:

“...are on duty 24/7 and should be contacted whenever a prisoner requires non urgent medical treatment or the Custody Officer believes that a prisoner should be medically assessed.”

88. Specific instructions to Custody Officers, important for present purposes, are set out at paragraph 5.23 of the *Risk and Vulnerability Guidance*:

“FITNESS TO BE DETAINED/ARRESTED

The Duty Custody Officer may decide that clinical attention is required before a decision can be made about a prisoner’s fitness to be held in custody... They should also be aware that the effects of alcohol or drugs

might mask other illnesses or injuries.

Where such a requirement is deemed necessary, the duty NHS nurse must be contacted and appraised of the circumstances.

The Duty Custody Officer must ensure that all relevant information is made available to the NHS nurse...

People who are found by police in a drunk and incapable condition pose significant issues for the police and welfare procedures for these individuals requires specific mention.

Alcoholism is a disease and when sufferers are denied further alcohol or medical intervention, serious physical damage could be caused or in extreme cases, a chain of events could be triggered which result in closing down of essential bodily functions including vital organs which might then result in death.

The effects of excessive alcohol consumption can mask other physical conditions, for example, head injuries and/or concussion. Duty custody officers should consider seeking medical opinion prior to accepting a drunk and incapable prisoner into a PCU.

Under no circumstances will an unconscious or unresponsive prisoner be admitted to any Tayside PCU.” (emphasis on original)

89. The *Risk and Vulnerability Guidance* was intended to supplement, but to be consistent with, existing guidance on related matters issued by the Association of Chief Police Officers in Scotland (ACPOS). In particular an ACPOS *Custody Manual of Guidance* exists, version 8 of which was produced for 2011/2012 (hereafter “the *ACPOS Guidance*”). A copy of this was not lodged in the present proceedings, but relevant passages are referred to and quoted in Crown Productions 3 (Bundle page 42) and 4 (Bundle page 146).

“3.3.4 Consideration should be given to transporting a custody directly to hospital if they:

- Have suffered a head injury
- Are or have been unconscious
- ...
- Are drunk and incapable and treatment centres are not available
- ...

3.4 Alcohol Treatment Centres (ATCs)/Drunk Tanks

3.4.1 Police Officers should escort a person found drunk and incapable to an ATC or drunk tank where available, as opposed to Custody Suites.

3.4.2 A drunk and incapable person should only be taken into Police custody if no other suitable place is available and no other suitable person can be traced to care for the person. In this circumstance consideration should be given to having the person assessed by medical staff prior to arrival at the Custody Suite.

3.4.3 All Forces should seek to pursue alternatives to Police custody with their respective local authorities.

...

Appendix 2 – Medical Care

...

Alcohol – Further Information

When dealing with persons believed to be intoxicated with alcohol, staff should be aware that:

- Alcohol is a poison in its own right and custodies can die of alcohol poisoning;
- Head injury victims ... may appear to be drunk;
- ...
- **Custodies should be able to walk to the cell and say a few words. If not they should not be put in a cell but transferred to hospital...** (my emphasis)

90. Police Scotland came into existence on 1 April 2013. It produced instruction and guidance to police officers relevant to the same issues as the Tayside Police and ACPOS guidance: *Police Scotland Care and Welfare of Persons in Police Custody Standard Operating Procedures (Version 1.00)* (hereafter “the *Police Scotland Guidance*”). Again, no copy of this document was lodged in the present proceedings, but it is referred to and quoted in Crown Productions 3 (Bundle page 40) and 4 (Bundle page 146).

“5.3 CUSTODIES SUFFERING FROM INJURY/ ILLNESS/ INTOXICATED BY DRINK/DRUGS

5.3.1 In certain circumstances a custody must be taken directly to a hospital after apprehension rather than being taken to a Custody Centre, to ensure suitable medical assistance is provided at the earliest opportunity. This may require the Arresting Officers to summon an ambulance crew or remove the custody directly to hospital.

Any requirement for immediate or urgent medical provision takes priority over apprehension. These circumstances may include where

the custody:

- Has suffered a head injury;
- Is or has been unconscious;
- ...
- Is drunk and incapable (unless local arrangements are in place to provide care;
- ...

APPENDIX T

...

When dealing with persons believed to be intoxicated with alcohol, staff should be aware that:

- Alcohol is a poison in its own right and custodies can die of alcohol poisoning;
Head injury victims ... may appear to be drunk;
- ...
- ...
Custodies should be able to walk to the cell and confirm their details. If not they should not be put in a cell but transferred to Hospital... (my emphasis)

It was not established exactly when this document was issued.

91. Training on the *Prisoner Care Guidance* and the *Risk & Vulnerability Guidance* was given to officers of Tayside Police. Sgt. Assenti received training on both in 2010. Detailed training materials were produced in power point form covering the issues from these two guidance documents which are highlighted above.

92. In connection with prisoner care and welfare the training powerpoint (Crown Production 18) contains a slide in the following terms:

“Medical Issues

Alcohol and Drug Misuse

Drunkenness remains a significant factor in some deaths in custody and imposes a burden on the Police who have to deal with often severely intoxicated people who might be better cared for elsewhere

- Most common problem in custody
- Potent risk factor for suicide
- Alcoholic most likely to have a fit whilst sobering up”

93. In connection with risk assessment the power point was produced by Chief Inspector Gordon Milne and Sergeant Alan Kidd (now lodged as Crown Production 22). In particular it included a slide in the following terms:

“Roles and responsibilities

Fitness to be Detained/Arrested

While the initial decision rests with the detaining officers, once within the custody environment it is solely the Custody Sergeant's remit to assess a detainee's fitness to remain.

Where such a requirement is deemed necessary, the duty NHS nurse must be contacted and appraised of the circumstances.

PLEASE NOTE THAT UNDER NO CIRCUMSTANCES WILL AN UNCONSCIOUS OR UNRESPONSIVE PRISONER BE ADMITTED TO A TAYSIDE PCU"

In another slide in the same presentation the role of the Custody Officer is highlighted as "guarantor of the suspect's rights" and as "a major guardian of the standards of the whole system."

94. As a result of this training, and his long experience as a custody officer, both the *Prisoner Care Guidance* and the *Risk and Vulnerability Guidance* were familiar to Sgt. Assenti. They were both available to him at Perth Police Office in electronic form. There is no evidence to suggest that on 7 May 2013 Sgt. Assenti was aware of, had access to, or had been specifically trained in relation to either the ACPOS or Police Scotland instructions/guidance, insofar as they went beyond or differed from the Tayside Police Guidance materials already referred to. At this time Sgt. Assenti was due to attend refresher training which may have included specific training on these materials.
95. A further recommendation made by Chief Inspector Milne in the *Custody Review* was that defibrillators be placed in Tayside Police Offices and that custody sergeants should have training in the use of them. It was as a result of this recommendation that a defibrillator was available to Sgt. Assenti on the evening of 7 May 2013, and that he knew how to use it.

Custody Audit, Perth Police Office

96. In November 2013, prompted by the events in the present case, investigators from the office of the Police Investigations and Review Commissioner carried out an audit of all persons received into police custody at Perth Police Office in the period between 1 December 2012 and 5 April 2013. The aim was to investigate whether there were any systemic failings in the standard of prisoner care at this office in the period prior to the reception of the deceased on 7 May 2013. The

audit was led by James Bonner. He has been a PIRC inspector for 6 years following 30 years experience as a police officer with Strathclyde Police, 6 of which were as a custody sergeant. The report of this audit is lodged as Crown Production 36.

97. Mr. Bonner and his colleagues examined a total of 1209 custody records over the 21 week period, completed by many different custody sergeants. They found all the relevant custody information (cell sheet form, custody check sheet form and electronic risk and vulnerability form) necessary for the audit was present for each record and filed in the divisional registry in a clear and accessible manner. As regards records of medical intervention, they found that 159 (13%) custodies were attended by the PC Nurse (that is, after travelling from Dundee to Perth for this purpose); 31 (3%) were attended by a Forensic Medical Examiner; 21 (2%) were removed to hospital from custody; and 3 (0.25%) were attended by paramedics in the cell area without need for removal to hospital. Overall more than 18% of all custodies had some form of medical assessment.
98. The investigators concluded that overall the custody records were completed to a high standard. They considered that the risk and vulnerability assessment which was required to be carried out in respect of each prisoner was being conducted in an appropriate manner and that the relevant documentation was being completed to show the reasoning behind the custody sergeant's rationale in determining the vulnerability grading for each prisoner. It was also clear to them that the risk assessment process was an ongoing consideration by each custody sergeant taking over the care of a prisoner.
99. Mr. Bonner's report concluded that:
- “Examination of the custody records shows that there would not appear to be any ‘culture’ of custody sergeants failing to adhere to the required process for determining the risk and vulnerability of persons brought into custody and to the contrary shows prisoners at Perth in general would appear to have received a high standard of assessment and care whilst in custody.”
100. However the investigators did not specifically address the question of how many persons were taken into custody on the grounds that they were drunk and incapable. They were unable to obtain data on whether or not any of the persons removed to hospital were kept there or returned to Perth Police Office after assessment. Their report does not throw any light on the question of the

circumstances in which drunk and incapable persons were being admitted to custody at Perth Police Office, and thus the particular question of how custody sergeants were interpreting and applying in practice the highlighted instruction at the end of paragraph 5.23 of the *Risk and Vulnerability Guidance*, nor the extent to which they were aware of or interpreting this instruction consistently with the guidance at Appendix 2 of the ACPOS *Custody Manual of Guidance*, again as highlighted above.

Health and Safety Executive Investigation

101. In August 2013 an investigation was instructed into whether the circumstances of the deceased's treatment at Perth Police Office disclosed a systematic liability in relation to custody handling at this office. This was a joint investigation between the Police Investigations and Review Commissioner and the Health and Safety Executive. The HSE report of this investigation is lodged as Crown Production 4 and is a true and accurate record of its findings and conclusions.

102. The HSE's investigation was thorough and detailed. It concluded that:

“There is no evidence to suggest that Sgt. Assenti's actions caused the death of [the deceased]. There is no evidence to suggest that had Sgt. Assenti followed procedures and made arrangements for the deceased to be taken to hospital instead of being placed in a cell in the custody unit it would have made any difference to the outcome... Although Sgt. Assenti did not follow all the procedures, he did assess (albeit not on paper) that [the deceased's] risk and vulnerability required that half hourly checks be carried out. He also contacted the duty nurse concerning the condition of [the deceased]. This is not a demonstration of a reckless disregard for [the deceased's] health and safety.”

It was therefore concluded that there were no good grounds to prosecute Sgt. Assenti under section 7 of the Health and Safety at Work Act 1974.

103. In conducting their investigation the HSE inspectors had access to Mr. Bonner's audit of the Perth Police Office custody records. They examined matters further however and found that during the period between 1 December 2012 and 5 April 2013 27 persons were arrested and taken to Perth Police Office for being drunk and incapable. The records showed that each custody had the correct vulnerability risk assessment forms completed per procedure. It was possible to establish that two persons had been admitted to custody even though not all the initial risk assessment questions had been answered, although these prisoners were

said to have been responsive on each occasion per the visit record. It was not possible to ascertain how an unresponsive intoxicated person would have been dealt with, that is whether they would have been taken to hospital or left to sober up in a cell. Nor was it possible to determine the standard by which ‘responsive’ or ‘unresponsive’ was being judged by custody sergeants, for example, the extent to which it was being interpreted consistently with the instruction at Appendix 2 of the ACPOS *Custody Manual of Guidance*, highlighted above.

104. Overall, the HSE report concludes that:

“...There is no evidence to suggest that there were systemic failures throughout Tayside Police’s Perth Custody Unit to follow the policy and procedures in place... It appears that the training provided to custody staff including custody sergeants was comprehensive...[They] had all received the relevant training and plans were in place for refresher training... Tayside Police... did fail to audit the implementation of these procedures by their custody staff... [however] no direct causal link can be made between the actions of Police Scotland and the death of [the deceased]. It is therefore HSE’s opinion that Police Scotland did not fail to discharge their duty under section 3(1) [of the Health and Safety Act 1974] in respect of the death of [the deceased]...”

Accordingly no criminal proceedings under the 1974 Act were brought against either Sgt. Assenti or Police Scotland.

NOTE:

Introduction

1. I heard evidence and submissions in this inquiry over five days between 20 and 27 May 2015. Evidence was led by the Procurator Fiscal Depute and was subject to cross examination by Mr. Reid, on behalf of the Chief Constable, Mr. Vaughan on behalf of PCs Heafey and Donnan, and Mr. Watson on behalf of Sgt. Michael Assenti.
2. I have appended to this determination a list of the names and designations of the witnesses called by the Procurator Fiscal Depute to give oral evidence, set out in the order in which they did so. No oral evidence was led on behalf of any other party. A joint minute was agreed and lodged. In particular it was agreed that the medical report by Dr. Robin J Northcote, lodged on behalf of Sgt. Assenti, truly and accurately reflects his interpretation of the evidence made available to him and his views and opinions in relation to same.

3. Members of the deceased's family were present in court initially, but left in the course of the medical evidence, and did not return. They were not legally represented and did not play an active part in the hearing. I extend my condolences to them.

Where and when the death took place

4. This evidence of the place and time of death was clear and undisputed. Dr. Kossko gave evidence that he pronounced the deceased's life extinct at 04.00 hours on 11 May 2013, within the Intensive Care Unit, Perth Royal Infirmary, Taymount Terrace, Perth, PH1 1NX.

The cause or causes of death

5. Again, this was clear and undisputed on the evidence of Dr. David Sadler, who performed the post mortem examination. The direct cause of the deceased's death was a cardiac arrest induced by high alcohol concentration and respiratory depression, against a background of chronic alcoholism and atherosclerotic coronary heart disease.

Whether there were any reasonable precautions whereby the death might have been avoided

6. In my view there were no reasonable precautions whereby the deceased's death might have been avoided. That is not to say that nothing could have been done differently. It is that even if it had, the deceased would still have died.
7. As the evidence made clear, the deceased suffered from two serious medical conditions: chronic and severe alcoholism, and severe coronary heart disease. The first of these was known to his GP and local health services. The second was not discovered until after his death. As a result of both conditions he was at high risk of cardiac arrest, and his prospects of survival in the event of such an event were significantly reduced. On 7 May 2013 he consumed such an enormous amount of alcohol that he is likely to have suffered respiratory depression. This, in combination with his coronary heart disease, is likely to have induced his cardiac arrest.
8. Given that his coronary heart disease was undiagnosed, the increased level of risk to the deceased of a cardiac arrest was unknown and unforeseeable. And in any

event the actual occurrence of such an arrest remained unpredictable. Having suffered it, however, the deceased's prospects of survival were very low, and would have been very low regardless of where he had been when it happened. In fact it happened when he was in Cell 2 at Perth Police Office, lying on a mattress in the recovery position. However he was discovered very shortly afterwards and thereafter swift and appropriate action was taken to resuscitate him by police officers and paramedics, albeit that ultimately fatal brain damage to him had by then already occurred.

9. Even if the deceased had been in hospital rather than in a police cell, I consider there is no reason to suppose that he would not still have suffered a cardiac arrest when he did, or that the outcome would have been any different. If he had been taken to and admitted to hospital he would likely have been placed on a bed in a normal ward, in the recovery position. He would likely have been checked at no more regular intervals than he was in Cell 2 at Perth Police Office. When he suffered the cardiac arrest, it is unlikely to have been detected any sooner had he been in hospital, or treated any more appropriately, or with any better long term outcome, than in fact occurred.
10. In my view this conclusion reflects the clear weight of evidence of the various medical professionals. It is perhaps most firmly expressed in the report by Dr. Robin Northcote, Consultant Cardiologist, but Dr. Forster gave clear and compelling oral evidence to the same effect, and ultimately none of Drs. Sadler, Patton or Kossko supported a contrary view.

Whether there was a defect in any system of working which contributed to the death

11. In my view there was no defect in any system of working which contributed to the death. This is not to say that the evidence established no defect in any such system, but rather that the deceased would have died even if such defects had not been present, and they did not contribute to it.
12. The reasons for this are the same as in relation to the question of whether there were reasonable precautions whereby the death might have been avoided. The deceased suffered an unpredictable and fatal heart attack, caused by severe intoxication against a background of alcoholism and coronary heart disease. No system of working, defective or otherwise, made any material contribution to this event.

Whether there are any other facts relevant to the circumstances of the death

13. This heading gives scope for consideration of other facts, relevant to the deceased's death, but which did not cause or contribute to it, insofar as they may affect the public interest.
14. There is no need for me to make any detailed comments about the events from the time that the deceased was discovered in cardiac arrest in Cell 2 at 19.00 hours on 7 May 2013, until his death in Perth Royal Infirmary three and a half days later. It is sufficient to say that the actions of Sgt. Assenti, his police colleagues, and the paramedics, in seeking to resuscitate the deceased, and then of the hospital medical staff in treating and caring for him, were entirely appropriate and represented the best efforts of all concerned in attempting to save his life. Nothing to the contrary was suggested.
15. However, in deference to the volume of evidence and argument which I heard on the matter it is appropriate to comment on the circumstances which caused the deceased to be in Cell 2 at the time of his fatal heart attack. In general terms this raises the question of the circumstances in which a person intoxicated with alcohol should be taken into police custody and detained in a police cell. This invites examination of the police policies and practices, their appropriateness, and the extent to which they were complied with, both generally and in the circumstances of this case.
16. It is of course far from being a novel problem. As Chief Inspector Milne explained, following deaths and other adverse incidents to persons in custody he carried out the wide ranging Tayside Police *Custody Review* in 2010. This led in particular to the development of the *Risk and Vulnerability Guidance* in an attempt to provide consistent, robust and defensible decision making in relation to the admission and care of persons in police cells. A significant aspect of this was recognised to be the regular difficulties of dealing with persons intoxicated with alcohol, who for reasons of their own and public safety were primarily in need of a safe and secure environment in which to sober up.
17. I was told that there were no Alcohol Treatment Centres ('drunk tanks') in Tayside. And it will not be appropriate to simply release a severely intoxicated person from custody unless there is a suitable person who can and will take care of them. As in the present case, such a person is often not available.

Accordingly at one level the issue boils down to whether publicly drunk and incapable persons should be the responsibility of the police or of the health service; whether they should be detained in a cell, or admitted to hospital.

18. I heard no evidence on the extent to which this issue had ever been addressed at a strategic level between Tayside Police and the relevant health board(s). What I did repeatedly hear however, both from the police and medical witnesses, was that hospital accident and emergency departments - including Perth Royal Infirmary - do not welcome being sent intoxicated persons by the police in order to provide them with a safe and secure sobering up environment. There is no doubt a variety of reasons why that might be so. There is no specific medical treatment available for intoxication. There may be pressure on hospital bed space and nursing resources. Intoxicated persons may be abusive to hospital staff and difficult to manage. They may not be willing to stay in hospital and may try to leave. In short, a hospital may well not be an appropriate place for an intoxicated person to be while sobering up. Thinking along these lines no doubt contributes to a further consistent line of evidence which I heard, namely that if an intoxicated person is sent by the police to hospital, they are as likely to be sent back to sober up in a police cell.
19. I also heard no evidence as to the reasons why there were no Alcohol Treatment Centres available. The *ACPOS Guidance* appears to seek to encourage their development. I raised the question whether the inquiry should be widened to consider this matter, but no party was in favour of this course. Given that there was nothing before me to suggest that the availability of an ATC might have prevented the deceased's death I did not consider that this was the appropriate case to consider this issue.
20. Against this general background the *Risk and Vulnerability Guidance* both seeks to confront the problem and to a certain extent - in my view - fudge it. It confronts the problem by setting out a well thought out and detailed risk assessment and decision making process, highlighting the difficulties associated with intoxicated persons. That is commendable, of course. On the other hand however the decision as to whether to admit an intoxicated person to a police cell is ultimately placed on the shoulders of the custody sergeant, whose decision will likely be made against a background of awareness of the difficulties typically presented by an intoxicated prisoner, and that if sent to hospital he is as likely to

be simply sent back. There was therefore a flavour to the evidence at points which suggested to me that a significant purpose of the risk assessment process in this area was to provide evidence with which to defend the decision making should something go wrong, rather than because it was anticipated that it would lead to major change in relation to the substance of the decisions which would still have to be made, on the ground, in the absence of realistic alternatives to police custody. To the extent that there may be any truth in this it seemed to me to place custody sergeants such as Sgt. Assenti in an unenviable position.

21. Prompted by the present case, and as detailed in the findings above, James Bonner carried out an investigation into the processing of all custodies at Perth Police Office over a 21 week period. Mr. Bonner, now a PIRC investigator, was able to provide an independent view of the custody recording and risk assessment in this office, based on many years relevant police experience outwith Tayside. It was clear that he was impressed with the overall standard of the recording and risk assessment which he saw after looking at more than 1200 cases. That is obviously positive, but his study had limitations for present purposes in that it did not directly address the situation of the decision making in relation to persons whose principal or only difficulty when brought to Perth was severe alcohol intoxication. The HSE investigation, spoken to by witness Alison Gillies, did identify that 27 cases of persons deemed drunk and incapable were processed at Perth. However this did not identify how many persons in this condition were admitted to police custody, attended on by the PC Nurse or forensic medical examiner, or sent to hospital - and if so with what result. Accordingly these studies did not answer important questions as to how the procedures based on the *Risk and Vulnerability Guidance* were actually operated in practice in relation to this group of prisoners, and with what result.
22. Further and in any event, the positive picture presented by Mr. Bonner has to be contrasted with other evidence available to me in the present inquiry. In particular, there is evidence of two occasions on which the deceased was brought to Perth Police Office, on 4 March 2013 and 7 May 2013. The CCTV footage which is available in relation to both these events makes for uncomfortable viewing. On the first occasion, in particular, the deceased was so intoxicated that he was unable to walk to the charge bar or stand. This took place within the period of the audit carried out by Mr. Bonner. On the second occasion, as set out

above, the deceased had to be wheeled in on the ambu-chair, and was unable to provide any coherent answers to questioning. On both occasions he urinated on himself. Yet on both occasions he was deemed fit to be admitted to custody and placed in a police cell. Additionally, PCs Heafey and Donnan gave evidence that they had never seen a person taken to hospital rather than police custody simply on account of their being drunk and incapable. PC Heafey, in particular, was an experienced officer. That he had never before seen this done might suggest that it was at best a rarity despite the instructions in the *Risk and Vulnerability Guidance*. In such circumstances the quality of the custody and risk assessment paperwork is one thing, but there remain concerns as to whether appropriate decisions were routinely being made as a matter of substance, that is, whether drunk and incapable persons were in general being admitted to police custody in Perth Police Office when they should not have been. Ultimately the evidence on this was inconclusive.

23. As the relevant witnesses were rightly keen to emphasise, proper risk assessment in relation to custody matters begins not at the charge bar but with the detaining or arresting officers. In this case I heard from PCs Heafey and Donnan. Having done so I am satisfied that it would not be justified to criticise them for their actions up until the point that the deceased arrived at Perth Police Office.
24. These officers were called to a disturbance which appears to have involved a fight between the deceased and his brother. On arrival both brothers were heavily intoxicated. There were good grounds to detain them in that a breach of the peace had taken place. Consideration was given to whether either brother required medical attention. A discriminating decision was then made. Ewan Milne was seen to have an apparently significant head injury, and as a result an appropriate decision was made to have him taken to hospital and assessed. The deceased's injuries however, including injuries to his scalp, were (correctly as it turned out) judged to be superficial and to not require hospital assessment. To simply leave him alone at his home, however, was not a safe or appropriate option for him, nor for the public given that a breach of the peace had occurred. At this stage, therefore, the decision to take the deceased to Perth Police Station was a reasonable one for the officers to take. Inevitably, given the distance, this took time, but I am satisfied that the deceased was treated appropriately and kept under reasonable observation throughout the journey.

25. The deceased's general treatment by these officers and Sgt. Assenti at Perth Police Office was however a cause of concern to me. The general problem, it seems to me, is that the deceased was a person suffering from a serious medical condition, namely acute intoxication due to alcoholism, and should have been treated as such. Instead, he was treated as an offender who was drunk. Furthermore, particular aspects of his treatment were poor. Although he must have consumed a significant quantity of alcohol, he was detained in the small cell compartment of the police van for more than an hour and a half without being given access to a toilet, as a consequence of which he urinated on himself. Although in no way offensive or abusive to the officers, nor actively resisting them in the performance of their duties, he was spoken of, and to, in a disparaging and at times aggressive manner. Once taken to Cell 2 and stripped, for reasons that were never properly explained, he was not placed in available protective custody clothing but was rather left naked under a blanket. All this displayed insufficient respect for his basic human dignity, and was inconsistent with the 'primary concern' of the *Risk and Vulnerability Guidance*, quoted above.
26. As I have already determined, none of these aspects of the deceased's treatment contributed in any way to his death. And I acknowledge of course that the officers concerned were operating in the real world, in a busy police office, where a robust approach to the persons with whom they are required to deal will very often be appropriate, indeed necessary. But had it been properly acknowledged that the problems manifested by the deceased were medical problems, as emphasised by the guidance under which the officers were required to operate, then in my view a different approach should have been recognised as being appropriate.
27. Similar considerations apply to Sgt. Assenti's decision to admit the deceased into custody at Perth Police Station. Notwithstanding the considerable efforts of Mr. Watson to persuade me to the contrary, I am quite clear that the deceased should not have been admitted to police custody without his first being medically assessed.
28. First, it was known that he was suffering from a medical condition, namely alcoholism. Second, he was so intoxicated that he was unable to walk to the charge bar or stand. He had to be wheeled in the ambu-chair, a device intended for persons with physical disabilities. Third, while he was able to say a few

words, he was too intoxicated to be able to provide any information at the charge bar sufficient to enable Sgt. Assenti to make a fully informed assessment of whether he was fit to be admitted to custody. Fourth, he had scratching and grazing injuries to his scalp. While these appeared superficial, it was believed that they had likely been caused as a result of the deceased engaging in a fight. Fifth, his condition had appreciably worsened in the two and a half hours since his arrest, even although he can have consumed no more alcohol during this period. This at least raised a question as to whether his condition at the charge bar was due to simple intoxication, or whether there was in addition an underlying medical problem (for example a head injury being masked by the effects of intoxication). PC Heafey did not tell Sgt. Assenti about this, and Sgt. Assenti's brief questioning of him did not elicit this information.

29. Given all this, and leaving aside for a moment the question of compliance or otherwise with the relevant guidance materials, the deceased should in my opinion have been taken to hospital, or at least medically assessed, prior to a decision being made in relation to whether he should be admitted to custody.
30. I acknowledge that at the time Sgt. Assenti was a very experienced and respected custody sergeant. All the police witnesses who had worked with him gave evidence to this effect, as did PC Nurse Reid. I have no doubt that his was an often difficult and demanding job, calling for firm decision making and the exercise of judgment in stressful and pressured situations. I also have no doubt that Sgt. Assenti recognised the importance and responsibility of this role and took it seriously. There is no question, as the HSE report quoted above states, of his acting with 'reckless disregard' for the deceased's health and safety; indeed the reverse is true. However having heard and considered all the evidence I am satisfied that his decision to admit the deceased to custody without a prior medical assessment was wrong.
31. Much attention focused during the hearing on whether this decision was done in breach of the *Risk and Vulnerability Guidance*. This contained a clear instruction to Sgt. Assenti as custody officer, and of which he was aware, that under no circumstances should a prisoner 'unconscious or unresponsive' due to alcohol intoxication be admitted to custody. Accordingly there was much evidence and argument about whether the deceased was truly 'unconscious or unresponsive' at the charge bar.

32. Sgt. Assenti's position was that the deceased was both conscious and responsive. As far as he was concerned these meant the same thing. He had not had previous dealings with the deceased, but had a lot of experience in dealing with intoxicated persons at the charge bar. He was aware from this experience that the health service would not welcome him sending the deceased to hospital. He felt that it was his responsibility to deal with the deceased; one that he should not abrogate. He did not accept that he had done anything wrong, other than not going through the twelve questions with the deceased, although it is clear that he saw this as simply a matter of form in the circumstances, not substance – in effect a tick box exercise. Overall it was submitted on his behalf that whether or not the deceased was 'responsive' was a judgment for him to make, and that his decision was one which in the circumstances he was reasonably entitled to make.
33. There is some force in all this. In particular the deceased plainly was not unconscious. He was largely able to sit unaided in a chair, hold up his head, and occasionally move his arms. And he was able to speak a few simple words at various points.
34. In my view however 'unconscious' and 'unresponsive', as ordinary words of the English language, do not mean the same thing. If they had been intended to mean the same thing, there would be no need to include the word 'unresponsive' at all, given that a person who is conscious is always likely to be responsive to at least some small degree, for example, to a pain stimulus. Therefore whether a person who is conscious is nevertheless to be considered 'unresponsive' suggests that this is intended to be a matter of degree. How was this to be judged?
35. The words 'unconscious or unresponsive' used at paragraph 5.23 of the *Risk and Vulnerability Guidance* were authored by Sgt. Alan Kidd, who was also charged by Chief Inspector Milne to lead training on the new procedures set out in this document. I therefore placed some weight on his comments in relation to this phrase and its application in the present case by Sgt. Assenti. He accepted that there were questions of judgment for the custody sergeant, but said that the general intention was that if the prisoner could not 'walk and talk' he should not be accepted into custody. Having himself viewed the CCTV footage of the deceased he said that "alarm bells" should have been ringing for Sgt. Assenti, particularly in that the deceased was in the ambu-chair and could not answer any of the twelve risk assessment questions. Overall he did not consider that the

deceased was assessed to the standard which he should have been. He would not have accepted him into the custody suite at all. He accepted that if sent to hospital he might be sent back, but at least he would have been medically assessed as a result.

36. I also attached weight to the view of Chief Inspector Gordon Milne, an officer of considerable seniority and experience, who as I understood it had overall responsibility for producing Tayside Police's *Custody Review* and also the *Risk and Vulnerability Guidance*. Having reviewed the available evidence in relation to the admission of the deceased to custody, including the CCTV, he did not consider that the risk assessment procedures which he had sought to put in place had been properly carried out. In particular he too criticised the use of the ambulance to bring the deceased into the charge bar. He also criticised the lack of detail in the risk assessment forms, and in particular that no mention had been made of the fact that the deceased had been unable to stand at the charge bar. His view was that if a prisoner was unable to answer questions that would in itself raise a question about whether he should be going into custody. He expected the risk assessment questions to be gone through even if there were difficulties eliciting answers. He recognized that this might not be easy, but expected custody sergeants to do their best in this regard. He agreed that these questions and the ability to answer them gave a proper context to assessment of 'responsiveness'. It was not just a tick box exercise. Overall, on the evidence available to him, he would have rated the deceased as 'unresponsive' in terms of the guidance which he had authored, and would not have put him in the cells.
37. I also thought it telling that PSCO Gordon said (and Sgt. Kidd thought she was correct) that there was no drop down menu available to her to enter 'unable to answer' in response to the 12 self risk assessment questions. This was why she entered instead 'non-cooperation'. This appeared to suggest that the computer programme relative to the risk assessment process was set up in such a way that envisaged that a person who was 'unable to answer' would *not* be processed, that is, not admitted to custody. PSCO Gordon suggested at one point in her evidence that it would have been appropriate to have asked the deceased these questions later, after he had sobered up, but in my view that cannot be right. The purpose of these questions is to inform the decision whether or not to admit a prisoner into custody, as well as to inform ongoing risk assessment thereafter. PSCO Gordon's

evidence in this connection seemed to me to carry a flavour (although this was not her position) that some officers did not feel that the policy instructions which they were being given in relation to intoxicated persons reflected the reality ‘on the ground’, and that it was therefore sometimes necessary to ‘work around them’.

38. Overall it seemed to me that the risk assessment process envisaged in relation to intoxicated persons in the *Risk and Vulnerability Guidance* required the active engagement of the prisoner, at least to the extent of his being assessed as *sufficiently* responsive to be mentally and physically *able* to answer the twelve questions set out in the document lodged as Crown Production 10. In other words, the ability to answer these questions provides a yardstick against which a prisoner’s responsiveness, and thus his fitness for custody, should be measured. It is therefore a matter of substance, not merely a formality to be observed. Of course, a prisoner may not answer these questions because he is being obstructive, not because he is unable to do so. That is a matter for judgment. However as recorded on the second page of the document at Crown Production 10, this was not the case with the deceased. What is recorded, entered as free text, is that he was assessed by Sgt. Assenti as being “unable” to answer because of intoxication.
39. The *Risk and Vulnerability Guidance* did not of course incorporate the passage in the appendix to the *ACPOS Guidance* to the effect that an intoxicated person who was unable to walk to the cell and answer a few questions/confirm their details, should not be admitted to custody. I was not entirely clear why this was not done. On the one hand Sgt. Kidd seemed to suggest that he thought these requirements might be too prescriptive. On the other he interpreted ‘unconscious or unresponsive’ as a ‘walk and talk’ test. That is of course now explicitly the test in the *Police Scotland Guidance*, and it is possible that it has led, as some witnesses suggested, to a significant reduction in the number of intoxicated persons admitted to police custody in Tayside since 2013. Be that as it may, if a person is too drunk to stand or walk or give useful or coherent answers to basic questions, then even under the *Risk and Vulnerability Guidance* these seemed to me to be important factors which would suggest that he was not sufficiently ‘responsive’ to be properly admitted to custody.
40. To sum up: the ‘unconscious and unresponsive’ test in the *Risk and Vulnerability Guidance* can be criticised for not being prescriptive enough. As what was intended was a ‘walk and talk’ test, this could and should have been spelt out. On

the other hand, even in the absence of such prescription, I do not consider that Sgt. Assenti properly applied the ‘unconscious and unresponsive’ test. The deceased should not have been assessed as ‘responsive’ in circumstances where he was as a result of intoxication unable to walk to or stand at the charge bar nor provide answers to any of the questions required by the risk assessment procedure.

41. In my view it is sufficient to say in the circumstances of the present case that the deceased should not have been admitted to police custody without *first* being medically assessed. If that meant sending him to hospital for medical assessment only for him to then be returned to the police station and taken into custody, so be it. If it meant the PC Nurse attending at Perth from Dundee, again, so be it - although as I understood the evidence this ultimately was a decision for the PC Nurse, not the custody sergeant. The deceased presented at the charge bar with an acute medical problem, namely severe intoxication due to alcoholism, his condition deteriorating, and with an apparently superficial head injury sustained in a fight. Sgt. Assenti, commendably, saw this as his responsibility, and one which he did not wish to abrogate. In my view, and with respect to him, he was wrong. It was in the first instance the responsibility of the health services to medically assess the deceased, and to decide whether or not he was medically fit to be detained in police custody. Police officers inevitably gain experience dealing with persons suffering from alcohol dependency. But this condition is a medical problem, which may be present coincidentally and perhaps masking other medical problems. Police officers are not medically qualified. Indeed it seems to me to be unfair to persons in Sgt. Assenti’s position that they should in effect be expected to act as if they are.
42. In the deceased’s case prior assessment at hospital or his prior assessment by the PC Nurse would have made no difference. But in another case it might, and on the basis of what I have heard it is the health services and the medical professionals, and not the custody sergeants, who should bear the risk.
43. A final point in connection with risk assessment at the police office, albeit again ultimately one of no practical significance in this case, is that the deceased was only found to have a dental plate when attempts were being made to revive him by Sgt. Assenti at 19.00 hours on 7 May 2013. This is concerning, as such a plate might represent a choking hazard for a severely intoxicated person. None of the police officers thought to check for this earlier. None of the twelve questions on

the self risk assessment form is directed to whether the person has any medical or dental implants etc. Consideration should in my view be given to including such a question. An inability to answer it through severe intoxication would again underline the need for medical assessment prior to admission to police custody.

Conclusions

44. I am satisfied that the police officers attending at Kinloch Rannoch on the afternoon of 7 May 2013 considered, in the light of the deceased's state of intoxication and his head injury, whether to have him medically examined there, or taken to hospital, or taken to Perth Police Office. I am satisfied that their decision to take the deceased to Perth Police Office was a discriminating decision, and one which was reasonable in the circumstances.
45. Given the condition of the deceased by the time he was presented at the charge bar at Perth Police Office, and all the other circumstances of the case, the custody sergeant should have had the deceased medically examined or taken to hospital to be medically examined prior to or instead of admitting him to police custody.
46. Aspects of the deceased's treatment at Perth Police Office failed to give proper respect to his basic human dignity, and were inconsistent with the stated primary concern of all custody staff, namely the protection of the well being of prisoners and treatment of them with care and consideration. The decision to admit the deceased to police custody having been taken, however, the steps taken to safeguard his health and safety thereafter were adequate and appropriate.
47. Guidance and training for police officers previously in place in Tayside for safeguarding the welfare of persons in police custody failed to make clear that persons so intoxicated by alcohol that they were unable to walk to and stand at the charge bar and answer appropriate risk assessment questions should not be admitted into custody without prior medical assessment. That is however now made sufficiently clear in guidance since issued by Police Scotland.
48. Consideration should be given by Police Scotland to including, as an appropriate risk assessment question for persons presented at the charge bar, whether he or she has any medical or dental implants or plates.

Sheriff Simon Collins QC

Perth, 28 September 2015

APPENDIX:

Witnesses called by the Procurator Fiscal to give oral evidence:

- 1. Police Constable Kevin Heafey**
- 2. Police Constable Mark Donnan**
- 3. Police Sergeant Michael Assenti (retired)**
- 4. Police Security and Custody Officer Laura Kernan**
- 5. Police Security and Custody Officer Alison Gordon (retired)**
- 6. Julie Mackay, Paramedic, Ambulance Service**
- 7. Senior Police Custody Nurse Jacqueline Reid**
- 8. Dr. Gareth Patton, Specialist Registrar**
- 9. Dr. Michael Forster, Consultant Anesthetist**
- 10. Dr. Yevginey Kossko, Specialist Registrar**
- 11. Dr. David Saddler, Forensic Pathologist**
- 12. Michelle Gillies, Inspector, Health and Safety Executive**
- 13. James Bonner, Investigator, Office of the Police Investigation and Review
Commissioner**
- 14. Chief Inspector Gordon Milne**
- 15. Police Sergeant Alan Kidd**