SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 10

GLW-B368/21

DETERMINATION

BY

SUMMARY SHERIFF V MAYS

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

into the death of

CAROLINE McLEOD

GLASGOW, 21 FEBRUARY 2022

Findings

The sheriff, having considered the information presented at the fatal accident inquiry,

Determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act"), that:

(1) In terms of section 26(2)(a) of the 2016 Act, Caroline McLeod (born on 25 October 1977), died on 8 October 2019 at approximately 1805 hours within Glasgow Royal Infirmary;

(2) In terms of section 26(2)(c) of the 2016 Act, the cause of Caroline McLeod's death was :

1.a. Pneumonia

2. Chronic Obstructive Pulmonary Disease.

(3) Makes no findings in terms of section 26(2)(b), (d), (e), and (f) of the 2016 Act.

(4) In terms of section 26(2)(g) of the 2016 Act finds that there is confusion amongst Police Scotland staff as to who is responsible for contacting a Health Care Professional (HCP) in a situation where a person in custody is assessed as requiring to see a HCP but is then transferred from a custody suit in one police office to a custody suit in another police office.

(5) In terms of section 26(2)(g) of the 2016 Act finds that the marker placed on a person's custody record and displayed on the Police Scotland custody "whiteboard" screen, indicating that the custody requires to be seen by a HCP, may not be sufficiently clear and obvious.

Recommendations

AND FURTHER, the sheriff having considered the information presented at the Inquiry,in terms of section 26(1)(b) of the 2016 Act, makes no recommendations.

NOTE

[1] This determination is made following a fatal accident inquiry into the death of Ms Caroline McLeod (hereinafter referred to as "Ms McLeod").

[2] At the time of her death Ms McLeod was in legal custody as she had been remanded in custody at Glasgow Sheriff Court on 1 October 2019. Accordingly, this was a mandatory fatal accident inquiry, in terms of section 2(4) of the 2016 Act.

[3] The inquiry was held in Glasgow Sheriff Court on 5 January 2022.

[4] The following parties participated in the inquiry: (i) the Crown (represented by Ms A Allan, procurator fiscal depute, Glasgow); (ii) Police Scotland (represented by Mr J Reid, Solicitor for the Chief Constable); (iii); Geoamey (represented by Mr D Nicholson, Counsel)

and (iv) Mr Robert McLeod, Ms McLeod's father (represented by Mr K MacKenzie, solicitor, Moir and Sweeney).

[5] The proceedings took place in person in Glasgow Sheriff Court. The current guidance from Scottish Courts and Tribunal Service sates that fatal accident inquiries should take place by means of WebEx or other digital means unless there is specific reason to the contrary. On 21 December 2021 the procurator fiscal lodged a motion seeking to have the inquiry held remotely by WebEx. After considering written submissions from parties I refused that motion to ensure that Mr McLeod would be able to participate effectively in the proceedings. In the end Mr McLeod did not attend the inquiry on 5 January 2022. Ms I Neill, Ms McLeod's mother, did however attend the inquiry and heard the oral evidence. No other persons appeared at the inquiry or intimated an interest in the inquiry.

[6] Fatal accident inquiries are now governed by the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"). The form of a Determination is prescribed by rule 6.1 (.e Form 6.1) of the 2017 Rules which requires the inclusion of certain information within the Determination. In this Determination, I have set out much of this information in the attached Appendix.

[7] I am grateful to all those appearing in the inquiry for their professional contributions, and for the assistance they gave to me during the course of the inquiry. Much of the evidence in the inquiry was agreed by parties in a joint minute. The inquiry was conducted efficiently as parties questioned witnesses only on relevant matters and did so in an effective manner, allowing the evidence to be completed in one day rather than the two days which had been allocated.

Procedural history

[8] On 14 April 2021 a notice of an inquiry was given by the procurator fiscal under section 15(1) of the 2016 Act.

[9] A preliminary hearing was assigned for 16 June 2021. That hearing was continued to 29 July 2021 due to the fact that (i) Mr McLeod had only recently instructed a solicitor and funding had not yet been obtained and (ii) CCTV footage, was lodged at the bar and so had only been made available to the parties on 16 June 2021. Parties were appointed to lodge a joint minute of agreed evidence prior to the next preliminary hearing and to clarify the witnesses which were to be called.

[10] On 29 July 2021 the preliminary hearing was continued until 7 September 2021 as (i) the solicitor for Mr McLeod had not yet been granted legal aid (ii) to allow the joint minute of agreement to be finalised and (iii) to allow the Crown further time to make enquiries with their expert witness in relation to CCTV footage.

[11] On 7 September 2021 the preliminary hearing was continued as (i) the legal aid application submitted by Mr McLeod solicitor had still not been determined (ii) for affidavits from five witnesses to be made available and (iii) to allow the Crown expert witness report to be finalised and (iv) for the signed joint minute to be lodged. A further preliminary hearing was assigned for 20 October 2021.

[12] On 20 October 2021 a further preliminary hearing was assigned for 3 December 2021 to allow (i) Mr McLeod's solicitor further time to view CCTV footage (ii) for Mr Reid to lodge

affidavits of two police witnesses and (iii) for parties to finalise the joint minute and lodge it with the Sheriff clerk. I assigned 5 and 6 January 2022 as the dates for the inquiry.

[13] On 3 December 2021 all matters discussed at the previous preliminary hearings having been attended to I continued the inquiry to the 5 and 6 January 2022.

[14] On 23 December 2021, for the reasons outlined in paragraph [5] above, I refused a motion made by the procurator fiscal that the inquiry be held remotely by WebEx and directed that the inquiry shall proceed in person within Glasgow Sheriff court on 5 and 6 January 2022.

Information made available to the inquiry

[15] On 5 January 2022, the inquiry was convened.

[16] A joint minute of agreement between the Crown, Police Scotland, Geoamey and Mr McLeod was lodged in process. In terms of the joint minute the following documents and other material were admitted in evidence (comprising volumes 1 and 2 of the Crown's productions and labels and Geoamey production number 1):

i. Intimation of Death Form of the deceased.

ii. Post Mortem Report relating to the deceased.

iii. STORM Incident Report.

iv. Full National Custody Record.

v. Prisoner Contact Record.

vi. Prisoner Escort Form.

vii. Scottish Ambulance Service Electronic Patient Record.

viii. Rapid Analysis Drug Lab Report.

ix. Addiction Records.

x. GP Records.

xi. Glasgow Royal Infirmary Medical Records.

xii. Police Scotland Standard Operating Procedure – Care and Welfare of Persons in Police Custody.

xiii. Police Scotland – Custody Transfer Guidance.

xiv. Geoamey Standard Operating Procedure – Fitness for Travel.

xv. Geoamey Standard Operating Procedure – Court Custody.

xvi. Geoamey Standard Operating Procedure – Medical Requirements.

xvii. Independent expert report by Dr Michael O'Keefe.

xviii. Supplementary independent expert report by Dr Michael O'Keefe.

xix. CCTV footage.

xx. Geoamey Prisoner Escort Record.

[17] Affidavits had been lodged on behalf of the parties. Oral evidence was heard from the following witnesses:

i. Police Constable Lee Miller

ii. Sergeant Stuart MacKenzie.

iii. Sergeant Alan Docherty.

iv. Geoamey officer, Russell Watt.

v. Geoamey officer June Bennett.

The affidavit of each witness was read for the record and thereafter parties had the opportunity to question the witnesses. I also asked questions of some of the witnesses for the purpose of clarifying certain issues.

[18] At the conclusion of evidence I appointed parties to exchange between them and lodge written submissions within 21 days. I appointed parties to advise whether a hearing on submissions was necessary within 7 days of written submissions being lodged. No party requested a hearing on submissions and on 4 February 2022 I made avizandum.

Closing submissions

Submissions for the Crown

[19] The Crown invited me to make mandatory formal findings under section 26(2)(a) and (c) of the 2016 Act in relation to the date and cause of Ms McLeod's death. There were no precautions which could reasonably have been taken or had they been taken which might realistically have avoided Ms McLeod's death (section 26(2)(e)). There were no defects in any system of working which contributed to Ms McLeod's death (section 26(2)(f)).

[20] It may be appropriate for me to comment on the fact that Ms McLeod had been identified as requiring to see a Heath Care Professional (hereinafter referred to as a "HCP") yet had not seen a HCP during her time in custody at Govan Police Office. This was an issue which was relevant to the circumstances of the death of Ms McLeod. An issue of potential poor practice had been identified. The Crown invited me to make any comments or findings I considered appropriate in terms of section 26(2)(g).

Submissions for the chief constable

[21] I should make formal findings in relation to the date and cause of Ms McLeod's death (section 26(2)(a) and (c) of the 2016 Act). There were no precautions which could reasonably have been taken and had they been taken which might have realistically resulted in Ms McLeod's death being avoided. There were no defects in the system of working which contributed to Ms McLeod's death. No findings should be made under section 26 (2)(e) and (f).

[22] There were two issues which might be considered as relevant to the circumstances of Ms McLeod's death and fall within the terms of section 26(2)(g). Firstly, who should be responsible for arranging an examination by a HCP when a custody is transferred from one custody suite to another. Secondly, how clear and obvious is any indicator or marker on the system that a custody has been marked as requiring to be seen by a HCP. It may be appropriate for Police Scotland to consider clarifying who is responsible for arranging an examination by a HCP in the situation where an examination has been requested but the custody is transferred from one custody suite to another. It may also be appropriate for Police Scotland to consider the custody "whiteboard" screen and whether the flashing green light HCP alert is sufficiently obvious.

Submissions for Geoamey

[23] I should make formal findings only in terms of section 26(2) (a) and (c) of the 2016 Act. No findings were appropriate in terms of section 26(2) (b), (d), (e), (f) and (g) of the 2016 Act. No recommendations were appropriate in terms of section 26(4) of the 2016 Act.

Submissions for Mr McLeod – next of Kin

[24] Formal findings should be made in relation to sections 26(2) (a) and (c) of the 2016 Act. No findings were appropriate in relation to section 26(2) (b) or (d) of the 2016 Act. I should consider making a finding in terms of section 26(2)(e) on the basis that if Ms McLeod had been examined by a HCP on being taken into police custody this might have resulted in an earlier diagnosis of her health condition and it might have been possible to take steps which would avoid her death.

[25] I should consider making a finding under section 26(2)(f). A flashing green light indicating that Ms McLeod required to be seen by a HCP had been added to her police custody record. Sgt Docherty did not read the whole custody record for Ms McLeod and had not noticed the HCP alert on the custody record. He did not fully interrogate the police custody record to ascertain whether or not it was recommended that Ms McLeod be examined by a HCP. There was a lack of communication between the relevant police officers in the transferring and receiving police offices. This was a defect in the system of working. It was accepted however that Dr O'Keefe had concluded that had Ms McLeod been seen by a HCP whilst in custody and sent to hospital at an earlier stage this would not have prevented her death

[26] If I was not minded to make a finding in terms of section 26(2) (e) and (f) on the basis that there may not have been a causal link between the perceived failings set out above and Ms McLeod's death it may be appropriate for me to comment on those perceived failings under section 26(2)(g) as other facts which are relevant to the circumstances of the death. The

identified failings indicated poor practice and were related to the circumstances of Ms McLeod's death

Factual circumstances

[27] Having regard to the information presented to the inquiry, I found the following facts to be established:

Events prior to Ms McLeod's arrest on 30 September 2019

(1) Ms Caroline McLeod was born on 25 October 1977.

(2) Prior to her arrest on 30 September 2019 Ms McLeod resided alone and was unemployed.

(3) Ms McLeod had 2 children who had been adopted at an early age.

(4) Ms McLeod was a patient at Springburn Health Centre, Glasgow and had been registered there since January 2016. Ms McLeod was last seen at the medical practice on 27 June 2019. At that appointment she complained of a cough and shortness of breath. She was offered a follow-up appointment on 7 August 2019 but failed to attend the appointment.

(5) Ms McLeod was prescribed a number of medications on a regular basis. She was prescribed Gabapentin 300 mg 4 times per day for chronic pain, Mirtazapine 30 mg for sleep and depression and Salbutamol and Seretide inhalers for asthma. Ms McLeod suffered from Chronic Obstructive Pulmonary Disease (COPD). This diagnosis is referred to in her medical records from 2016 onwards.

Ms McLeod was also underweight and had previously been prescribed nutritional supplements.

(6) Ms McLeod had used illicit drugs since her early twenties. Prior to her death Ms McLeod was known to be illicitly using diamorphine, cocaine and diazepam. She had been a patient of the Community Addiction Team for a number of years. She had been prescribed 70 mils of methadone daily since 2017. Ms McLeod was due to attend at the Community Addiction Team every 28 days but her attendance was sporadic due to her chaotic lifestyle and abuse of illicit drugs. Ms McLeod was last seen by a doctor in the Community Addiction Team in June 2018. She was referred to the Community Addiction Team in June 2019 following a request by Ms McLeod to be prescribed diazepam.

(7) During the period 2000 to 2018 Ms McLeod had accrued 15 criminal convictions for offences which included offences of dishonesty, possession of drugs and prostitution. At the time of her death she had 4 pending complaints outstanding, relating to allegations of theft and fraud and failing to attend court.

Events leading to Ms McLeod's arrest on 30 September 2019

(8) Around 21:00 hours on Monday, 30 September 2019 two members of the public saw Ms McLeod wandering outside the common close at an address in Glasgow. Ms McLeod was wearing pyjamas and a coat. The members of the public spoke to Ms McLeod but could not make sense of what she was saying and formed the opinion that she was confused and under the influence of some substance. They

did not smell alcohol coming from Ms McLeod. Miss McLeod had keys in her possession but was unable or unwilling to tell the members of the public where she lived. As the weather was cold the members of the public allowed Ms McLeod into the common close area and contacted the police to attend. The call was placed at 21:43 hours and police constable ("PC") Andrew Campbell and PC Lee Miller arrived at the scene at 21:58 hours .

(9) When they arrived Ms McLeod was sitting down in the common close and appeared to be drinking tea that had been provided by the members of the public. PC Campbell and PC Miller were able to establish Ms McLeod's name and date of birth but could not obtain an address from her. During this time PC Campbell and PC Miller observed Ms McLeod to be confused, cold, unkempt and possibly under the influence of something. They did not consider her to be overly intoxicated. Ms McLeod denied having taken any alcohol or drugs.

(10) A Police National Computer (PNC) check was undertaken which revealed that Ms McLeod had two outstanding warrants for her apprehension issued by Glasgow Sheriff Court. As a result Ms McLeod was arrested and placed in the rear of a police vehicle. Ms McLeod was able to walk to the police vehicle. Ms McLeod was not searched at this time due to the fact that both police officers in attendance were male. One of the officers sat in the rear of the police vehicle in order to supervise Ms McLeod during the journey to the police station. PC Miller did not consider that Ms McLeod required to be taken to hospital

rather than to a police station. There was nothing about her presentation that suggested to PC Miller that Ms McLeod required immediate medical attention.

(11) Ms McLeod was first taken to Baird Street Police Office. At Baird Street she was transferred into the custody of PC Wilson and PC Simson. Both police officers were provided with a briefing as to the circumstances of Ms McLeod's arrest by PC Miller and PC Campbell. Prior to being placed in the police vehicle by PC Wilson and PC Simson Ms McLeod was subject to a search. Nothing of note was found during the search. Ms McLeod was then taken to Glasgow City Centre Police Office. During the journey to Glasgow City Centre Police Office PC Wilson and PC Simson found Ms McLeod to be sleepy and possibly under the influence of something. When asked, Ms McLeod denied having taken any alcohol or drugs. Ms McLeod did not require to be handcuffed during the journey because she was compliant. Neither police officer had any concern at this time in relation to Ms McLeod's welfare.

Events at Glasgow City Centre Police Office

(12) Ms McLeod arrived at Glasgow City Centre Police Office at approximately 2229 hours on 30 September 2019. She sat in the holding area, alternating between sitting upright and sitting bent forward with her head resting on her knees until she was taken to the charge bar to be processed into custody at 23:05 hours.

(13) Ms McLeod was processed by Police Custody and Security Officer (PCSO) Spence in the presence of Police Sergeant Stuart MacKenzie. Sgt MacKenzie was working as custody sergeant on 30 September 2019. The vulnerability assessment questions were put to Ms McLeod and her answers recorded in the Full National Custody Record. Ms McLeod denied that she had taken any alcohol or drugs. She also denied having any medical conditions. She did however state that she was prescribed methadone and took gabapentin for arthritis. She said that she was drowsy as she had not slept and was tired.

(14) Sgt MacKenzie observed that Ms McLeod was able to walk, talk and answer questions. He observed that Ms McLeod had vomit stains on her pyjamas, appeared sleepy and to be under the influence of something. Sgt MacKenzie could not smell alcohol from Ms McLeod and formed the view that she had taken controlled drugs. He was not satisfied that the answers she had given in response to questions asked in the vulnerability assessment, when she denied that she had taken drugs, were truthful. He did not consider that Ms McLeod needed urgent medical treatment. Due to his concerns in relation to Ms McLeod's presentation Sgt MacKenzie recorded Ms McLeod to be "high-risk" and required her to be placed on constant observations. He noted in the custody record that she should be seen by a HCP as he was concerned that Ms McLeod had consumed illicit controlled drugs.

(15) As Sgt MacKenzie recorded in Ms McLeod's custody record at that she required to be seen by a HCP. The words "MEDIC ALERT" and "MEDIC REQUIRED:

YES" appear in the Police Full Custody Record (Crown Production no 3, page 18). Recording this information in the custody record created an alert on the custody system main computer system. All custodies are listed on the custody system main computer system. This is colloquially referred to as the custody "whiteboard". The HCP alert appears in the custody whiteboard in the form of a flashing green symbol. This symbol appears next to the name of the custody and signifies that the custody requires to see a HCP. For the HCP alert to be removed from the custody whiteboard a member of the custody staff would require to go into the computer system and remove the medic alert from the relevant custody's record.

(16) Sgt MacKenzie did not contact a HCP as Ms McLeod was being transferred to Govan Police Office. There is no HCP based at Glasgow City Centre Police Office. A HCP is based at Govan Police Office 24 hours a day.

(17) Sgt MacKenzie authorised that a strip search be carried out of Ms McLeod to check that she was not in possession of any illicit substances.

(18) A strip search was carried out by police constable Simson in the presence of PCSO Reddy at approximately 23:18 hours . Ms McLeod was found to have concealed in her bra a small plastic bag which contained 5 white tablets. Ms McLeod stated that the tablets were Valium but denied having taken any Valium. The five white tablets were later analysed and confirmed to be Etizolam, a class C drug controlled under the Misuse of Drugs Act 1971

(19) Due to a lack of available observation cells at Glasgow City Centre Police Office Sgt MacKenzie arranged for Ms McLeod to be transferred to Govan Police Office.

Events at Govan Police Office

(20) Ms McLeod was taken to Govan Police Office by PC Wilson and PC Simson. Ms McLeod arrived at Govan Police Office custody centre at approximately 23:56 hours on 30 September 2019. Sgt MacKenzie had phoned Govan Police Office to advise the custody sergeant, Sgt Alan Docherty, that Ms McLeod would be arriving from Glasgow City Centre Police Office. Sgt Docherty did not recall Sgt MacKenzie advising him that Ms McLeod required to see a HCP.

(21) Sgt Docherty had access to Ms McLeod's Full Custody Record. He looked at Ms McLeod's custody record prior to Ms McLeod arriving at Govan Police Office but he did not fully review her custody record. He looked only at specific sections of the custody record including the front page and the vulnerability assessment questions and answers. Sgt Docherty did not see the green flashing symbol indicating that Ms McLeod required to be seen by a HCP. The flashing green light symbol must have been visible on the Custody "whiteboard" as Sgt MacKenzie had recorded a medic alert in Ms McLeod's custody record.

(22) Sgt Docherty did not ask Ms McLeod for any medical information as this had been done at Glasgow City Centre Police Office prior to her being transferred to Govan Police Office. He carried out his own assessment of Ms McLeod when she arrived at Govan Police Office. He observed that Ms McLeod appeared to be

intoxicated. Her eyes were glazed and her speech was slurred but she was able to converse. Ms McLeod did not smell of alcohol. Sgt Docherty noticed vomit splattered on Ms McLeod's pyjamas and that she looked pasty but not unwell. Sgt Docherty was of the opinion that Ms McLeod was intoxicated due to drugs. He asked Ms McLeod whether she had taken any drugs but she denied that she had done so. Ms McLeod was able to walk to the cell unaided. Sgt Docherty asked Ms McLeod whether there was anyone who could bring fresh clothes in for her. Ms McLeod advised Sgt Docherty that there was no one who could do this and Sgt Docherty arranged for police issue clothes to be made available to Ms McLeod.

(23) Sgt Docherty did not have any concerns about Ms McLeod's welfare and determined that she did not require to be seen by a HCP.

(24) When an individual is intoxicated through drugs or alcohol there is a risk that they may vomit or fall causing injury to themself. Placing an individual on constant observations ensures that the individual is subject to constant monitoring and observation. This is a process used to manage any risk arising from intoxication through drugs or alcohol or withdrawal from either of those substances. Around 0009 hours on 1 October 2019 Ms McLeod was placed in a constant observation cell where she remained until around 0818 hours.

(25) Physical were checks were carried out on Ms McLeod every 60 minutes during her time on constant observations. Her cell was also covered by CCTV cameras. The CCTV cameras were monitored constantly by staff within Govan Police

Office. CCTV footage captured Ms McLeod within the observation cell during her time in Govan Police Office. Ms McLeod is seen to be mainly lying on her mattress in the cell. On a few occasions she is seen to walk to the toilet and use the toilet before returning to the mattress and lying down. Ms McLeod is seen to alternate between lying on the mattress and sitting with her back against the cell wall. Ms McLeod conversed with custody staff during their physical hourly checks upon her. Staff in Govan Police Office custody suite did not notice any deterioration in her condition or anything which might have required a change being made to Ms McLeod's care plan.

(26) Sgt Docherty finished his shift at 06:30 hours on 1 October 2019. Ms McLeod was removed from constant observations at some point after Sgt Docherty finished his shift. The need for a person to be subject to constant observation is kept under review. Where a person is on constant observations due to being intoxicated through alcohol or drugs as time passes their condition may improve and a decision may be taken to remove them from constant observations. A person who is not on constant observations initially can be placed on constant observations if there is concern for their well-being. A person who was subject to constant observations and then removed from constant observations can, if it is accessed to be necessary, be placed back on constant observations.

Events at Glasgow Sheriff Court on 1 October 2019

(27) At approximately 08:19 hours on 1 October 2019 Ms McLeod entered the holding area of Govan Police Office where she was transferred to the custody of Geoamey prisoner custody officers (PCO) Riach and Armstrong. Ms McLeod was handcuffed to PCO Riach and walked to the Geoamey prisoner transport vehicle. Neither PCO Riach nor PCO Armstrong had any concerns regarding Ms McLeod's well-being and she was taken to Glasgow Sheriff Court

(28) Ms McLeod arrived at Glasgow Sheriff Court at approximately 08:36 hours . She was taken to the front bar area within the custody court area at approximately 08: 46 hours .

(29) Ms McLeod was searched by PCO June Bennett and was found not to be in possession of anything. She was offered the opportunity to make use of the toilet facilities which she refused and was given water. Ms McLeod was then taken to the open plan female cell area.

(30) Between 09:15 hours and 11:45 hours Ms McLeod had a number of interactions with Geoamey staff including toilet visits and being provided with access to water and she had a visit from her solicitor. She left her cell on 6 occasions to access the toilet facilities and on one occasion to see her solicitor. She was provided with lunch and a drink. During this time no concerns were recorded in relation to Ms McLeod's well-being in the Prisoner Escort Form (Crown production number 6)

(31) At approximately 12:00 hours PCO Bennett recorded on the Prisoner Escort Form that Ms McLeod was feeling unwell, that Ms McLeod stated that this was due to "withdrawals" and that Ms McLeod had not been sick.

(32) Between 12:28 hours and 15:30 hours there are further interactions recorded on the Prisoner Escort Form relating to Ms McLeod including checks being made on Ms McLeod and toilet visits and access to water being offered and being taken up by Ms McLeod.

(33) CCTV footage within Glasgow Sheriff Court captured Ms McLeod whilst in the cell area. She is seen to be either sitting on the bench with her head on her knees, sitting upright, or walking about the cell. She is provided with access to water and can be seen walking from the cell on occasions to go to the toilet and on one occasion to see her solicitor. Ms McLeod does not appear to be unwell or in need of any medical intervention whilst in the cell (Crown label number 1 CCTV footage). Ms McLeod did not advise PCO Bennett that she had any respiratory problem. PCO Bennett did not see any signs of any difficulty with Ms McLeod's breathing prior to her appearing in court.

(34) Geoamey PCO Russell Watt was tasked with transferring Ms McLeod from the female cell area to court 4 of Glasgow Sheriff Court. PCO Watt attended at Ms McLeod's cell along with PCO Bennett. At this time PCO Bennett noticed a change in Ms McLeod's presentation. Ms McLeod looked more drained and tired. PCO Watt was advised by PCO Bennett that Ms McLeod was feeling unwell and was a bit unsteady on her feet. As a result PCO Watt suggested that

a wheelchair could be used to assist Ms McLeod to get to court 4. Ms McLeod was able to stand up in the cell, walk to the wheelchair and get into the wheelchair without assistance from either PCO.

(35) At approximately 15:56 hours Ms McLeod was taken to court 4 in Glasgow Sheriff Court by PCO Watt to appear in respect of the warrants upon which she was apprehended.

(36) Whilst PCO Watt and Ms McLeod were waiting outside court 4 for Ms McLeod's case to be called Ms McLeod was sitting slumped in the wheelchair. It was quiet outside the court and PCO Watt heard a crackle in Ms McLeod's chest when she was breathing. PCO Watt has personal knowledge of asthma and chest infections and was concerned that Ms McLeod may have a chest infection. Ms McLeod then told PCO Watt that she had COPD and that she had not had her medicine for a couple of days. She also stated that she had taken roughly 30 Valium.

(37) Ms McLeod appeared from custody respect of the warrants. She was represented by a solicitor who sought Ms McLeod's release on bail. Ms McLeod's solicitor advised the court that Ms McLeod suffered from COPD Bail was refused and Ms McLeod was remanded in custody by the presiding sheriff.

(38) PCO Watt returned Ms McLeod to the female cell area within Glasgow Sheriff Court. He was concerned about Ms McLeod so told PCO Bennett about the disclosures made by Ms McLeod and stated that he was concerned about Ms McLeod's health.

(39) At 16:35 hours PCO Bennett recorded in the Prisoner Escort Record the information which had been provided to her by PCO Watt. The information caused her to be concerned about Ms McLeod's condition and she informed a Geoamey team manager. A Geoamey team manager went to the female cell area to speak to Ms McLeod and found her speech to be very slurred. The Geoamey team manager summoned the court nurse to examine Ms McLeod.

(40) Ms McLeod was placed on constant observations until the arrival of the court nurse, Alison Saunderson. Whilst awaiting the arrival of the court nurse CCTV footage captures Ms McLeod in her cell. She is seen to be mainly sitting in the wheelchair with her head bent over but is moving and appears fully conscious at all times. At approximately 17:15 hours Ms McLeod stands up and sits briefly on the bench in the cell before pulling the wheelchair back towards herself and getting back into the wheelchair. She appears to speak to Geoamey staff on several occasions whilst in the cell.

(41) At approximately 17:25 hours Nurse Saunderson examined Ms McLeod and observed that she was having difficulty breathing and had a high temperature. Ms McLeod told Nurse Saunderson that she suffered from COPD Nurse Saunderson requested attendance of an ambulance and remained with Ms McLeod until paramedics arrived

(42) A call was made to the ambulance service at 17:31 hours and paramedics arrived at Glasgow Sheriff Court at 18:06 hours .

(43) Paramedics found Ms McLeod to be alert, warm to the touch and confused. Paramedics recorded in the Scottish Ambulance Service Electronic Patient Record (Crown production number 7) that she was breathing adequately. They administered oxygen, paracetamol and Salbutamol. Paramedics then transported Ms McLeod to Glasgow Royal Infirmary departing from Glasgow Sheriff Court at around 18:34 hours .

Events at Glasgow Royal Infirmary

(44) Ms McLeod arrived at Glasgow Royal Infirmary at 18:49 hours on 1 October 2019. On examination hospital medical staff found Ms McLeod to be significantly unwell, meeting the criteria for sepsis. Ms McLeod was diagnosed as having an unspecified acute lower respiratory infection. Ms McLeod underwent a CT scan which showed that she had pneumonia in both lungs and significant underlying lung disease. She was admitted to the high dependency unit before being moved on 2 October 2019 to the intensive care unit. This was due to the fact that she was no longer managing on high flow nasal oxygen and required to be ventilated.

(45) Ms McLeod remained in the intensive care unit at Glasgow Royal Infirmary between 2 October and 8 October 2019. Her condition fluctuated during this time between being "stable" and "deteriorating" (Crown production number 11).

(46) Whilst in intensive care medical staff found a plastic kinder egg containing a banknote concealed between Ms McLeod's legs. On 7 October 2019 a CT scan

was ordered to ensure that Ms McLeod had no further packages concealed internally within her body. Nothing further was found. The scan did however show that Ms McLeod's small-bowel had died due to a lack of blood supply. This may have resulted from a period of time where Ms McLeod had low blood pressure.

(47) On 8 October Ms McLeod's condition deteriorated significantly. Medics considered whether to perform surgery to remove the dead part of Ms McLeod's small-bowel. Medics concluded that Ms McLeod would not survive surgery and the decision was taken to make her comfortable.

(48) Ms McLeod was provided life extinct by Dr Ryan McKendry at approximately 18:05 hours on 8 October 2019 within Glasgow Royal Infirmary (Crown production number 2 and Crown production number 11).

(49) At the time of her death Ms McLeod's status was of a person detained in legal custody.

Post mortem examination

(50) A post-mortem examination of Ms McLeod's body was conducted on 21 October 2019 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist Dr Marjory Turner and Dr Gillian Wilson (Crown production number 2).

(51) The cause of death was recorded as:

1a. Pneumonia

2 Chronic Obstructive Pulmonary Disease.

(52) The post-mortem examination confirmed that Ms McLeod had severe and extensive pneumonia in keeping with the clinical diagnosis and which could be the consequence of aspiration and would account for her death.

(53) A history of chronic drug abuse can potentially predispose to the development of pneumonia but in Ms McLeod's case there was a background of fairly severe chronic lung damage (COPD) which would have likely been a more significant factor.

(54) Dr Turner and Dr Wilson considered the question of the effects of the potential ingestion of street Valium. No blood samples from the time of Ms McLeod's admission were available for analysis. Whilst any such intoxication could have been a significant factor in the development of pneumonia, in the absence of blood samples, this could not be either confirmed or excluded.

Independent expert review carried out by Dr Michael O'Keefe

(55) An independent expert review of the circumstances of Ms McLeod's death was commissioned by the Crown Office and Procurator Fiscal Service. Dr Michael O'Keefe undertook to prepare this report.

(56) After providing his report Dr O'Keefe was further instructed by the Crown Office and Procurator Fiscal Service to review the available CCTV footage of Ms McLeod during her time in custody and to provide a supplementary report. He was asked to provide an opinion on whether or not it would have been

obvious to staff members at Glasgow City Centre Police Office, Govan Police Office or Glasgow Sheriff Court, that Ms McLeod required medical attention, or that she was becoming more unwell during her period in custody.

(57) Ms McLeod did not disclose to any member of staff that she suffered from any medical condition affecting the respiratory system prior to telling PCO Watt that she suffered from COPD at around 16:00 hours on 1 October 2019.

(58) Ms McLeod did not display any clinical signs that she was suffering from a significant respiratory disorder, or of pneumonia or sepsis during the period she was in custody.

(59) Ms McLeod was provided with appropriate care by members of staff of Police Scotland and Geoamey during the time she was detained in custody.

(60) As soon as it became apparent to Geoamey staff that Ms McLeod suffered from COPD and her condition appeared to be deteriorating Geoamey staff acted appropriately and quickly by placing Ms McLeod on constant observations and in summoning a nurse to review Ms McLeod's condition.

(61) Prior to approximately 16:00 hours on 1 October 2019, in the absence of Ms McLeod disclosing that she had an underlying health condition, namely COPD, it would not have been obvious to Police Scotland staff or Geoamey staff - on the basis of the information that they had and from their observations during interactions with Ms McLeod - that Ms McLeod was, or was becoming, seriously unwell.

Discussion

[28] From information available to the inquiry it appears that Ms McLeod was a vulnerable individual who had struggled with addiction issues for a significant period of time. She also had underlying health conditions including COPD which had been diagnosed as far back as 2016.

[29] At the time of her arrest on 29 September 2019 it is likely that Ms McLeod was under the influence of illicit drugs. I have reached this conclusion on the basis of evidence provided by PC Miller, Sgt MacKenzie and Sgt Docherty as to Ms McLeod's presentation, the evidence that she was found to be in possession of tablets which were later analysed and found to be Etizolam and the evidence that she disclosed to PCO Watt on 1 October 2019 that she had taken approximately 30 Valium.

[30] I heard oral evidence from five witnesses in this inquiry. I found the evidence of all five witnesses to be credible and reliable and I accept their evidence. All of the witnesses gave evidence in a straightforward and honest way and seemed to me to be disposed to do their best to assist the inquiry. There were some minor inconsistencies in the evidence, for example, PC Miller made no reference to Ms McLeod's pyjamas being stained with vomit a fact which is referred to by both Sgt MacKenzie and Sgt Docherty. There was also at times uncertainty as to exactly what information had been passed on between staff. For example, Sgt MacKenzie thought he would have told Sgt Docherty in the short telephone conversation he had with him in relation to the transfer of Ms McLeod from Glasgow City Centre Police Office to Govan Police Office that Ms McLeod required to see a HCP but could not be sure about this. Sgt Docherty could not recall Sgt MacKenzie informing him that he was of the view that

Ms McLeod required to see a HCP. There was also uncertainty about where some of the information recorded in the Prisoner Escort Record had come from. PCO Bennett was unsure whether the information she had recorded at the entry timed 16:35 hours , the crucial entry which refers to COPD and to Ms McLeod having taken 30 Valium, had come from something which had been said during Ms McLeod's court appearance, information which had been passed to her from her colleague PCO Watt or information she herself had elicited by asking Ms McLeod. The witnesses were giving oral evidence more than 2 years after the events which concern the inquiry. That passage of time taken with the number of people that Police Scotland and Geoamey staff deal with on a day-to-day basis could explain the lack of certainty in relation to matters such as those referred to above. I do not find that issues such as those referred to above undermine the reliability of any of the witnesses. It was of note that all of the witnesses in their evidence demonstrated concern for Ms McLeod and her welfare and took the action they considered necessary to ensure that she received appropriate care and treatment during her time in custody.

Evidence of Doctor Michael O'Keefe

[31] I did not hear oral evidence from Dr O'Keefe but had before me his report (Crown production number 17) and his supplementary report (crown production number 18) prepared by him at the request of the Crown Office and Procurator Fiscal Service. There was no challenge to Dr O'Keefe's expertise from the other parties. Much of Dr O'Keefe's evidence was agreed by the parties in the joint minute. Dr O'Keefe is a registered medical practitioner of significant experience who has worked as a GP and also worked for a lengthy period as a

forensic medical examiner. I accept that he has the necessary expertise to provide an expert opinion on the circumstances surrounding Ms McLeod's death, with particular reference to the issue of whether it should have been apparent to those involved in caring for her during her time in custody that she was unwell and on the issue of whether any failure to ensure that Ms McLeod saw a HCP during her time in Glasgow City Centre Police Office or Govan Police Office had any causal connection to Ms McLeod's death

[32] Dr O'Keefe considered a large number of documentary productions including the Full National Custody Record, the Prisoner Contact Record, Scottish Ambulance Service Records, Ms McLeod's GP records and the hospital records relating to Ms McLeod's care and treatment in Glasgow Royal Infirmary between 1 and 8 October 2019. Dr O'Keefe also reviewed all of the CCTV footage covering Ms McLeod's detention in custody with a view to giving an opinion on whether or not it should have been obvious from her presentation that Ms McLeod was, or was becoming, seriously unwell.

[33] I place weight on the reports from Dr O'Keefe. In his reports he details the information that he has had regard to and explains clearly the basis upon which he has reached the conclusions in his report. There was no contradictory expert medical evidence.

[34] In his report Dr O'Keefe provides information in relation to COPD which is a chronic and progressive illness that cannot be cured. It is an inflammatory lung disease which involves the obstruction of the free passage of air in and out of the lungs. The symptoms can include difficulty in breathing, shortness of breath, wheezing, cyanosis, coughing and sputum (phlegm) production. Patients who have COPD have a higher than average risk of developing lung infections such as pneumonia. This can put them at higher risk of developing sepsis.

[35] Pneumonia is an infection that inflames the air sacks in one or both lungs. The air sacks may fill with fluid or puss causing a cough with phlegm or puss, fever, chills and difficulty breathing. A variety of organisms including bacteria, viruses and fungi can cause pneumonia.

[36] The signs and symptoms of pneumonia can include chest pain on breathing, coughing, confusion or changes in mental awareness, a cough which may produce phlegm, fatigue, fever, sweating and shaking or chills, low body temperature, nausea, vomiting or diarrhoea and shortness of breath.

[37] Dr O'Keefe provides evidence in his report about sepsis. Sepsis develops when the chemicals in the immune system released into the bloodstream to fight an infection cause inflammation throughout the entire body. This can lead to tissue damage, organ failure and death. Almost any type of infection can lead to sepsis. One of the places where sepsis most often starts includes the lung. Dr O'Keefe also provides evidence in relation to septic shock explaining that this occurs with the symptoms of severe sepsis and extreme low blood pressure which leads to major organ failure.

[38] Dr O'Keefe opines that Ms McLeod did not display any clinical signs of a significant respiratory disorder such as COPD while in custody. While her movements appeared at times somewhat slow and she appeared somewhat less than alert she had at no time showed signs of physical distress or obvious ill-health, In particular she did not show symptoms of a severe cough, shortness of breath, wheezing, cyanosis (blue discolouration of the skin particularly in face and lips), or sweating and shaking.

[39] Ms McLeod did not display any clinical signs of pneumonia during her time in custody. She did not have any chest pain on breathing or coughing, she did not appear to be confused

although she did appear to be drowsy. She did not have a persistent cough, a fever, sweats or shaking, or nausea, vomiting or diarrhoea and she had no shortness of breath until 15:56 hours on 1 October 2019.

[40] Ms McLeod did not display any clinical signs of sepsis when in custody prior to her court appearance. Ms McLeod responded properly to hourly checks and provided satisfactory verbal responses. She made no complaints of ill health and only once complained of feeling cold.

[41] Dr O'Keefe's opinion is that during her time in police custody Ms McLeod did not display any obvious or readily detectable signs of ill-health which indicated that she required urgent medical assistance or treatment until she developed noisy breathing at 15:56 hours and told staff that she had COPD.

[42] Following this information being imparted to staff appropriate measures were taken by PCO Watt in reporting the matter to his line manager, his line manager in calling for a nurse and Nurse Saunders calling for an ambulance. In Dr O'Keefe's opinion the care and treatment provided by the paramedics who attended at Glasgow Sheriff Court was entirely appropriate. Dr O'Keefe is of the opinion that Miss McLeod was provided with a wholly appropriate standard of care in accordance with the Police Scotland Care and Welfare of Persons in Police Custody Standard Operating Procedures.

[43] In the opinion of Dr O'Keefe it would not be reasonable for non-medically trained personnel in the absence of Ms McLeod complaining of ill-health to detect or diagnose Ms McLeod's underlying health condition based on her clinical presentation during her time in custody.

[44] Dr O'Keefe's evidence is that even if Ms McLeod had been seen by a HCP whilst in custody and sent to hospital at an earlier stage this would not have prevented her death. He is of the opinion that there is no causal link between Ms McLeod's failure to be seen by a HCP within Govan Police Office and her death.

[45] Having regard to the evidence in the report from Dr O'Keefe and having considered the terms of the agreed productions, the joint minute, the oral evidence and the written closing submissions I do not consider it appropriate to make any findings in terms of section 26(2)(e) and (f) as I was invited to do by Mr MacKenzie.

[46] There is no evidential basis upon which I could make a finding that had Ms McLeod been seen by a HCP in Glasgow City Centre Police Office or Govan Police Office that this would have been a precaution which might realistically have prevented her death. There is no evidential basis upon which I could make a finding that there was any defect in any system of working, arising either from the failure to communicate information regarding the requirement for Ms McLeod to see a HCP or Sgt Docherty's failure to fully interrogate Ms McLeod's custody record, which contributed to Ms McLeod's death. While Sgt Docherty did not read all of the information included in Ms McLeod's custody record he did look at the vulnerability assessment and also made his own assessment of Ms McLeod's presentation. Having considered the information in the vulnerability assessment and his observations of Ms McLeod he determined that she did not require to see a HCP. In oral evidence Sgt Docherty confirmed that it was for the individual custody sergeant to make an assessment as to whether or not any particular custody required to see a HCP. Dr O'Keefe's evidence is that even if Ms McLeod had been seen earlier by a HCP in Govan Police Office this would not have prevented her death.

[47] I am of the view however that whether Ms McLeod should have been seen by a HCP, why she was not seen by a HCP and who is responsible for arranging for a HCP to see a person in custody when a custody is transferred from one police office to another are matters relevant to the circumstances of her death.

[48] Sgt MacKenzie was of the view that Ms McLeod required to see a HCP due to her presentation when he processed her at Glasgow City Centre Police Office. He thought that the answers she gave to the questions in the vulnerability assessment did not accord with her presentation. He thought that she was under the influence of drugs and required to see a HCP. As she was being transferred to Govan Police Office he did not phone a HCP himself and request that a HCP see Ms McLeod at Govan Police Office. He did not request a HCP visit as he was aware that HCP's were stationed at Govan Police Office 24 hours a day. He added information that Ms McLeod required to be seen by a HCP to the Custody Record which meant that a flashing green symbol was displayed on the Custody "whiteboard" screen. This flashing green light symbol indicates that the custody requires to see a HCP. The flashing green symbol was referred to in evidence by Sgt Docherty as a "medic alert". It would appear on the screen next to Ms McLeod's name when her custody record was accessed at Govan Police Office. Sgt MacKenzie was of the view that this would alert those responsible for receiving the custody at Govan Police Office that Ms McLeod required to see a HCP.

[49] From the evidence it is clear that the flashing green light symbol indicating that Ms McLeod required to see a HCP was displayed on her custody record when her record was accessed at Govan Police Office by Sgt Docherty. Despite this Sgt Docherty did not recall seeing the symbol which indicated Ms McLeod required to see a HCP. In his evidence Sgt Docherty

stated that the custody "whiteboard" screen on which he viewed the names and details of custodies allocated to Govan Police Office was "a very busy looking screen". He went on to state that "once you knew your way around it it was okay but the first time he had seen the screen he had thought that he would never know how to work it."

[50] The custody "whiteboard" screen is the only real opportunity for a custody sergeant dealing with a transferred in custody to see that another police custody sergeant thought it appropriate that the individual see a HCP. Sgt Docherty's evidence was that the only other way the receiving custody sergeant would know that a HCP was required was to go into the custody record and go through one or more drop-down boxes to reach the section which would include the "medic alert" information, which indicates whether the individual requires or does not require to see a HCP. It was clear from the evidence of Sgt Docherty, who is an experienced custody sergeant, that he would not routinely go through the stages required to access the "medic alert" in the Prisoner Custody Record. What is generally relied upon is the flashing green symbol which appears on the custody "whiteboard" screen which lists all the custodies being transferred to or detained in an individual police office.

[51] That being the case it is a matter of concern that custody sergeants who require to access information quickly and accurately find the screen "very busy" such that they may miss seeing the flashing green symbol which alerts them to the fact an individual has been assessed as requiring to see a HCP.

[52] Sgt Docherty accepted that the green symbol was obvious but stated that there could be many lights on the custody "whiteboard" screen including alerts indicating matters other than the requirement to see a HCP. The question arises as to whether the flashing green symbol is a

sufficiently obvious marker on the custody "whiteboard" screen to prevent it being potentially missed due to the large volume of other information on the "whiteboard" screen when there is a large number of people in custody in any particular police office.

[53] As the flashing green symbol is the most immediate indicator that a person in custody requires to see a HCP and is the one which tends to be relied upon by custody sergeants who may not access the full prisoner custody record, it needs to be displayed on the custody "whiteboard" in a way which makes it as clear as possible to avoid it being inadvertently missed.

[54] Given the evidence that Ms McLeod's death would not have been prevented even if she had seen a HCP earlier there is no basis upon which I can make a formal recommendation under section 26(4) of the 2016 Act. I do think that it would be prudent for Police Scotland to review the custody "whiteboard" screen when it is showing custodies at full capacity in the police office which has the largest capacity to accommodate custodies. This should be done with a view to Police Scotland considering whether any further action requires to be taken to ensure that the green symbol indicating that the custody requires to see a HCP is sufficiently obvious that it cannot be missed by someone looking at the screen when the custodies in the relevant police office are at full capacity.

[55] Police Scotland should consider whether any modification requires to be made to the current way of displaying the information on the custody "whiteboard" which alerts custody sergeants or other staff within the custody suite to the fact that a particular person requires to see a HCP.

[56] The second issue which arises is that it appears that there is some confusion as to who is responsible for contacting a HCP in a case where the individual was transferred in custody from one police office to another police office.

[57] Sgt MacKenzie did not think that it was necessary for him to phone a HCP as he had created the "medic alert" and knew that HCPs were based at Govan Police Office and available there 24 hours a day. On the other hand Sgt Docherty's evidence was that it was for the transferring custody sergeant to phone the HCP and ask for the custody to be seen, not the sergeant receiving the custody. He stated that if he was transferring a custody out to another police office then he would phone the HCP to let the HCP know that the custody required to be seen. In his evidence he referred in passing to section 18 of the Police Scotland Standard Operating Procedure – Care and Welfare of Persons in Police Custody. He was not questioned further about this reference nor referred to the relevant document during his evidence. I inferred from his evidence that Sgt Docherty was of the view that section 18 provided guidance on this issue.

[58] Section 18.1.1 of the Police Scotland Standard Operating Procedure - Care and Welfare of Persons in Police Custody Version Number 13 dated 30/10/2018 ("the Standard Operating Procedure") provides that should medical advice and or/assistance be required in relation to any prisoner, it is the responsibility of the custody supervisor to make direct contact with the HCP. The guidance does not however specify which custody supervisor's responsibility this is where the prisoner is being transferred to another police office. It may perhaps be inferred that it should be the custody supervisor who initially assessed the prisoner as requiring to see a HCP but this is not expressly stated. I have also considered the Police Scotland – Custody

Transfer Guidance. This Guidance does not cover the issue of who has responsibility for contacting a HCP when a custody is transferred from one police office to another police office.

[59] The guidance at paragraph 18.1.2 of the Standard Operating Procedure provides that a reference should be made to a HCP if there is any reason to believe that a prisoner has taken drugs. While Ms McLeod denied taking drugs both Sgt MacKenzie and Sgt Docherty were of the view that she was under the influence of drugs meaning that they must have considered that Ms McLeod had taken drugs. In terms of the Standard Operating Procedure it would appear that she should therefore have been seen by a HCP. My impression from the evidence was that while those who were suspected of being under the influence of drugs or alcohol were put on constant observations they did not always see a HCP. Sgt Docherty in his evidence said that he was of the view that it was likely that Ms McLeod had been marked to see a HCP as she was "withdrawing" from drugs. Sgt Docherty was clear that he had made his own assessment of Ms McLeod and based on his observations and interactions with her and the information accessed in her custody record she did not require to see a HCP.

[60] He stated that even if he had seen the flashing green symbol indicating that a HCP was required this would not have caused him to review his decision because he had carried out his own assessment and concluded that Ms McLeod did not need to see a HCP. He did however state that if Sgt MacKenzie had told him that Ms McLeod required to see a HCP then he would have arranged for her to see a HCP. That perhaps somewhat contradicts his evidence that even if he had seen the green medic alert symbol on the custody "whiteboard" he would not have reviewed his assessment that Ms McLeod did not need to see a HCP.

[61] In Ms McLeod's case there is no evidential basis for suggesting that if she had seen a HCP earlier this would have prevented her death. The evidence is that even if she had seen a HCP earlier during her time in custody this wold not have prevented her death. It would be speculation to consider whether she might have told any HCP assessing her that she had taken drugs (given she had already denied so doing to several police officers) or would have told the HCP that she had COPD It again it would be nothing more than speculation to suggest that if she had been examined by a HCP that it was a possibility that the HCP would have identified any symptoms consistent with a severe respiratory disorder.

[62] There is no evidential basis for making a formal recommendation under section 26(4) of the 2016 Act. Nonetheless it seems to me that it should be clear to those with responsibility for processing custodies who is responsible for contacting a HCP and arranging for a custody to be seen by a HCP when a person in custody is transferred from one police office to another police office.

[63] In order to avoid any similar confusion arising in other cases it would be prudent for Police Scotland to review and consider amending the Standard Operating Procedure and the Police Scotland – Custody Transfer Guidance. This should be done to make it clear in cases where a prisoner has been assessed as requiring a HCP by a custody sergeant but that prisoner then requires to be transferred to another police office due to, for example, capacity issues, which custody sergeant is responsible for contacting the HCP. It would appear sensible that this should be the custody sergeant who initially assessed the prisoner as requiring to see a HCP. If this was to happen it would also obviate any difficulty arising from the receiving police

custody sergeant failing to notice the flashing green symbol on the custody "whiteboard" screen indicating that the prisoner requires to see a HCP.

[64] Finally I offer my sincere condolences to Ms McLeod's father and mother, to other members of her family and to her friends. Ms McLeod's family have exhibited great patience in awaiting this inquiry and the outcome of the inquiry.

APPENDIX

The legal framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3) of the 2016 Act. It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1) of the 2017 Rules).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. An inquiry can be conducted by a sheriff principal, a sheriff or a summary sheriff exercising the powers of a sheriff. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1).

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of

working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.