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STATEMENT 2 JUNE 2009

INQUEST INTO DEATH OF CALLUM MCLEAN IN POLICE CUSTODY CONCLUDES WITH AN APOLOGY FROM GREATER MANCHESTER POLICE

18-29 May 2009
Before HM Coroner for South Manchester, John Pollard
Sitting at Stockport Magistrates Court, Edward Street, Stockport, SK1 3NF.

The inquest into the death of 41 year old Callum McLean concluded on Friday 29 May with a public apology to the family from Greater Manchester Police (GMP) in open court. The thorough investigation and inquest were completed just over a year after Mr McLean died. Clear systemic problems were identified and the coroner has used his powers under rule 43 of the Coroners Rules to write to the police, ambulance service and the General Medical Council about the case in a bid to prevent another tragedy. Disciplinary proceedings have been recommended against two custody sergeants and a custody detention officer.

Mr McLean was detained on the afternoon of 10 April 2008 and taken to Ashton under Lyne police station where it was noted he had a head injury. Later that evening he was transferred by ambulance to Tameside General Hospital. Mr McLean died when a decision was made to turn off his life support machine on 11 April 2008.

The family had hoped that the inquest would examine their serious concerns about the level of care whilst at the police station and whether any actions or failings by the police and the Forensic Medical Examiner could have contributed to his death.

The inquest established that Callum McLean died after he was left in a cell for nearly three hours without proper medical attention. He had sustained a head injury as a consequence of either a fall or an involvement in an assault some time previously. On arrival at the police station a Forensic Medical Examiner (FME) was contacted due to his condition but there was a substantial delay before the doctor arrived, during which time he was only visited once and then only a cursory look was made through the spy hole of the door of his cell.

The Police and Criminal Evidence Act 1984 Codes of Practice 9.3 requires that

> *Those suspected of being intoxicated through drink or drugs…must, subject to any clinical directions given by the appropriate health care professional… be visited and roused at least every half hour.*

When the FME visited Mr McLean at just after 8pm, four hours after his arrest, he described Mr McLean as being "half dead" and left him alone in his cell while an ambulance was called. When they arrived, two ambulance technicians assessed his level of consciousness as

level 6 on the Glasgow Coma Scale. When Mr McLean received a CT scan he was found to have a subdural haematoma which was irreversible by surgery. He died at 3.30pm the following day 11 April 2008.

The jury returned a detailed narrative verdict which exposed a catalogue of individual and systemic failings by Greater Manchester Police and the ambulance service including:

- That there were no reasonable grounds for the custody office to downgrade him from a medium risk to a low risk during the booking in process;
- that the Police and Criminal Evidence Act 1984 codes of practice were breached and he should have been placed on a regime of half hourly visits;
- there were no systems in place to ensure that the indicated levels of checking as set out in the custody record were in fact being carried out;
- there was not an adequate system within the custody suite to ensure that vulnerable detainees were sufficiently monitored;
- that in fact Mr Mclean was not visited at all between 5.41pm and 8pm;
- that there was not sufficient and adequate training including refresher training for those involved in his detention;
- that the FME did not request all the necessary information or give adequate advice to the custody staff during the initial telephone conversation with the custody sergeant;
- that the FME was slow to respond and following finding Mr McLean unconscious and unable to be roused in a foetal position on the floor of the cell he did not carry out an adequate medical examination or place him in the recovery position;
- that it was inappropriate for the FME not to stay with him for the 21 minutes pending the arrival of the ambulance;
- that the level of care offered by the FME was inadequate and unacceptable and that if he had to leave the cell he should have asked a police officer to remain with Mr McLean and should have spoken directly to the ambulance crew about the seriousness of his condition;
- that the ambulance crew should have asked to speak directly to the doctor on arrival at the police station and that they were given insufficient information by the police about the condition of Mr McLean and that whilst the examination they carried out was adequate they failed to call ahead to alert the hospital of their arrival, to travel with blue lights and sirens, to bypass the queue and take him straight to triage or to monitor him on arrival.

At the conclusion of the inquest, Chief Inspector John Brennan of GMP Professional Standards Branch, apologised to the family in open court saying that "we have failed the family and we are sorry about that." He added that having spoken to the family he knew that they wanted to know that this will not happen again and said: "we will alter our systems to ensure that it does not happen again". CI Brennan had given evidence to the inquest which indicated that during the time Mr McLean was in custody there were an additional 18 detainees in custody, nine of whose care caused him to want to ask questions.

Callum McLean's family were represented by INQUEST Lawyers Group members barrister Sean Horstead of Garden Court Chambers, instructed by Fiona Borrill of Lester Morrill Solicitors, Leeds.

Notes to editors:

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts and conducts policy work on the issues arising.

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