

# Report of a Complaint Handling Review in relation to Strathclyde Police

under section 35(1) of the Police Public Order and Criminal Justice (Scotland) Act 2006

## Summary and Key Findings

The applicant is dissatisfied with how Strathclyde Police handled the investigation of the sudden death of her husband. She also believes that a police officer who dealt with her husband's death "bullied" her.

Of the five complaints made by the applicant, the Commissioner concluded that three were outside his statutory remit and therefore could not be included in his review. In respect of the remaining two complaints (complaints 1 and 5), the Commissioner found that neither had been handled in a reasonable manner. In respect of complaint 1, the Commissioner found that there had been a significant delay in recognising this as a formal complaint. In respect of complaint 5, the Commissioner concluded that Strathclyde Police's response did not adequately reflect the findings of the investigating officer.

In light of these, and other deficiencies in the handling of the complaints, the Commissioner recommended that Strathclyde Police apologise to the applicant.

The Commissioner highlighted the fact that his conclusions related solely to the manner in which the complaints were handled, and not to their substance. In the Commissioner's view, there was nothing in the points raised by the applicant in her statements to justify her conclusion that Person A's death was not investigated at the time.

The Commissioner also identified two learning points: the first concerning the need for police bodies to keep auditable records of enquiries undertaken into complaints; the second regarding the need for regular, written updates to be issued to complainers where enquiries into their complaints become extended.

## The Commissioner's role

Section 35 of the Police Public Order and Criminal Justice (Scotland) Act ("the Act") gives the Commissioner the power to examine the manner in which a policing body has dealt with a "relevant" complaint, as defined in the Act.

The Commissioner is independent of the police service and performs his functions in a fair and impartial manner. Before considering a complaint, the Commissioner's office obtains all papers held by the policing body against which the complaint has been made. These papers are considered alongside information provided by the applicant. The Commissioner then assesses whether the policing body's handling of the complaint was reasonable in all the circumstances. The Commissioner will look at the entire handling process, from the initial investigation by the policing body to the final response issued to the applicant. Among the factors which the Commissioner takes into account are the following:

- whether the policing body's response to the complaint is supported by all material information available;
- whether in dealing with the complaint the policing body has adhered to all relevant policies, procedures and legal provisions;
- where the complaint has resulted in the policing body identifying measures necessary to improve its service, whether these measures are adequate and have been implemented;
- whether the policing body's response to the complaint is adequately reasoned; and
- whether the policing body has communicated with the applicant in a reasonable manner.

## Background

### *Introduction*

In June 2001, the applicant's late husband, Person A, was working in Scotland as a musician with a touring circus. He, the applicant and their family lived in England at the time (although the applicant's first language is not English).

While on tour, the applicant lived in a small "cabin" within a vehicle known as a "bunk wagon". Each cabin within the bunk wagon had its own door and window. There was a Calor gas heater inside each of the cabins, with a connector tube leading to a common bottled gas supply located outside.

According to the sudden death report produced by Constable D, fellow band members recalled that, immediately after their evening performance on Friday 15 June 2001, Person A went off to bed in his accommodation at around 10 pm, as was apparently his routine. When, unusually, Person A had not turned up for rehearsal on Saturday 16 June, his fellow band members (Persons F and G) went to his cabin and saw through the window that Person A was lying face down on the floor, still dressed in his outdoor clothes. Person F climbed through the window of the cabin and opened the door from within. At this time, the heater was still on in Person A's room. It was obvious to Persons F and G that Person A was dead. An ambulance was called and paramedics could find no sign of life. It appeared to them that Person A had been dead for some time.

The police were called and Constables B and C attended. They were told of the circumstances by witnesses. The ambulance crew pointed out the heating system and the possibility that Person A's death may have been due to carbon monoxide poisoning owing to a lack of ventilation in the cabin.

The heater was examined and found to have a rubber hose connecting it to the gas cylinder. The connection was found to have no seal and appeared to have been poorly fitted. Interviews conducted at the time with Person A's fellow band members revealed that none had complained of feeling ill due to the heating system.

Medication used to treat high blood pressure was found within Person A's cabin. Although the applicant was aware that Person A suffered from angina and high blood pressure, Person A had not informed his fellow band members of this. While on tour Person A had complained to the applicant about his living and working conditions. In particular, he complained that as part of his duties he was required to "set up the stage" and also that his cabin was small, dirty and uncomfortable. According to the sudden death report, in the weeks prior to his death Person A's fellow band members had noticed him become drowsy and said that he had missed some notes during performances. In the two days prior to his death he had complained of pains in his arms which he had to massage.

The Police Surgeon, Doctor Z, attended and at about 3.15 pm pronounced life extinct. He could find no suspicious circumstances and concluded that there was no prima facie evidence of foul play. He estimated the likely cause of death as coronary thrombosis and the time of death as 11 pm on 15 June 2001. Doctor Z was satisfied that the ventilation available was sufficient to prevent carbon monoxide poisoning. As Doctor Z did not have access to Person A's medical history, he recommended that a post mortem take place to confirm the cause of death.

According to Chief Inspector E's report prepared in connection with the applicant's subsequent complaints, on 18 June 2001 Doctor Z was asked by the Procurator Fiscal to issue a death certificate without a post mortem. This was on the basis that Doctor Z had found nothing untoward and that no concerns had been raised by the police investigation. Doctor Z agreed to issue a death certificate on that basis.

On an unrecorded date following Person A's funeral, a copy of a document from the local Procurator Fiscal's office, dated 2 July 2001, was passed on to the applicant by the undertaker. This document recorded the time and cause of death and authorised the release of Person A's body for cremation. The document is in the following terms:

*"... I [Principal Procurator Fiscal Depute] hereby certify that I have made investigation into the death of [Person A] ... and that I am satisfied that his death took place on 15 June 2001 at 2300 hours.*

*The cause of his death has been ascertained by post mortem examination to be coronary thrombosis.*

*There are no circumstances which would render necessary any further examination of the body of the deceased.*

*No reason is known by me why the body of [Person A] should not be removed ... to [the applicant's home town] for cremation there."*

#### *Doctor Z's account*

In June 2006 the applicant wrote to Doctor Z with the help of an advocacy service. Doctor Z later responded in some detail with his recollection of the events surrounding his examination of Person A's body and the recording of the cause of death.

In his letter, Doctor Z wrote that, despite the passage of time, his memory of attending Person A was good. He had also "looked into the concerns raised ... as thoroughly as possible in order to ensure that [his] responses were factually accurate". Doctor Z explained that he had attended the scene of Person A's death and was "given a history by the police officers present, which would be

normal practice in such circumstances". He noted that he formally pronounced life extinct and clarified the fact that Person A's past medical history was not known at that time. Doctor Z was shown some medication that Person A was known to have been taking and was aware that this was used to treat either hypertension or angina. He noted the following:

*"Careful external examination of [Person A] was in keeping with him having died the previous evening at approximately 2300 and there were no signs of external violence.*

*I concluded that there was no prima facie evidence of foul play or criminality and I reached the view that the likely cause of death was a coronary thrombosis.*

*Because I did not have access to his past medical history at that point, I recommended that an autopsy (post mortem examination) take place. The report I wrote out at the time was then submitted to the Procurator Fiscal along with additional information from the Police Officers present."*

Doctor Z further stated that, on the following Monday, he was telephoned by the Procurator Fiscal who asked if he would be willing to offer a death certificate, given that he had "found nothing untoward" and that "no concerns were raised by the police investigation". He explained in his letter that issuing a death certificate in this way is known as "View and Grant" and that it is something which happens on a fairly regular basis. Dr Z concluded:

*"Clearly, I did not attend [Person A] but in the situation outlined here the Fiscal asked if I was agreeable to so, I felt it was appropriate to issue a death certificate and that I could do this to the required standard, ie **to the best of my knowledge and belief** giving the cause of death as coronary thrombosis with there being an increased chance of this occurring with either hypertension or angina." [emphasis in original]*

#### *The accounts of Constables B and C*

According to their respective statements (which appear to have been provided in July 2008) Constables B and C attended the circus camp at approximately 2 pm on Saturday 16 June 2001. On arrival, they contacted the band leader, Person F, who told them that he had last seen Person A the previous night during the show, which had ended at 10 pm. When Person A failed to turn up for practice on the morning of 16 June 2001, Person F and another band member - Person G - contacted Person H, who was occupying the bunk next door to Person A. According to Person F, Person H had informed him that he had not heard Person A snoring during the night, although he was known to be someone who generally snored loudly.

On arrival, Constables B and C met the paramedics, who were still at the scene. The paramedics, they said, "suggested the possibility of carbon monoxide poisoning". Constables B and C state that they requested that a supervising officer and a police casualty surgeon attend. They note that Doctor Z attended shortly thereafter and examined Person A in their presence. Constable B stated that "the fire was pointed out to Doctor [Z] but he discounted this as a possible cause of death". Constable C stated:

*"I believe he [Doctor Z] stated that if the death had been due to carbon monoxide poisoning the deceased would have been more pink and the window within the cabin would, in fact, have afforded sufficient ventilation."*

According to Constables B and C, Person F informed them that Person A suffered from a heart condition. Doctor Z, they recalled, would not issue a death certificate due to the absence of medical history for Person A, and he instructed that his body be removed to the mortuary until the Procurator Fiscal could be consulted on the following Monday.

Neither officer found any sign of disturbance or forced entry to Person A's cabin. They noted on their arrival that the gas heater had already been turned off by those who had found the body.

### *Constable D's account*

At the time of the incident, Constable D's duties included compiling sudden death reports and arranging for them to be submitted to the Procurator Fiscal. He stated that on Sunday 17 June 2001 he received a hand-written sudden death report submitted by Constable C. At some point that day he visited the playing field where the circus company had set up. There, he spoke to members of the circus company and viewed Person A's accommodation. On returning to his office, he updated and prepared a sudden death report for submission to the Procurator Fiscal. To the best of his recollection he left it to a colleague (unnamed) to obtain Person A's medical history and submit the report. There appeared to be no suspicious circumstances.

Constable D stated that the applicant had asked that a post mortem be carried out and that he spoke to the Procurator Fiscal about the matter. The post mortem, he said, was declined by the Procurator Fiscal.

When later asked to clarify elements of his statement, Constable D stated

*"I was asked if I could recall going to the locus of the death. To the best of my recollection I believe I went to the Circus and spoke to a number of people there. I do not know their names due to the passage of time. I can remember going and seeing the bunk wagon but I can't remember if I entered it. I have been asked if I can recall interviewing any witnesses. If I had gleaned any information I would have added it to the Sudden Death Report. I can't remember what information I may have got due to the passage of time and my notes being destroyed. In particular, I have been asked about the deceased complaining about pains in his arms and missing notes. I can't remember if I obtained this information or not."*

### *The Death Certificate*

The death certificate noted that Person A's death was registered on 22 June 2001 and that he had been "Found dead 2001 June 15<sup>th</sup> 2300 hours ... within caravan within [the circus camp]".

The cause of death was listed as coronary thrombosis.

## **The Complaints**

Based on the contents of the application form, correspondence received from the applicant, and the information obtained from Strathclyde Police, the Commissioner has identified the following complaints:

- (1) that Constable D bullied the applicant when talking to her on the phone following Person A's death;
- (2) that Person A's body was not subject to a post mortem examination;
- (3) that there is a discrepancy in the recorded time of death;
- (4) that Person A's body was not returned to the Coroner for a Post Mortem to be carried out there; and
- (5) that Person A did not die of natural causes and Strathclyde Police failed to investigate this.

The applicant first contacted Strathclyde Police regarding her concerns on 9 February 2006, almost 5 years after Person A's death. In her letter, which is headed "Complaint to Constable D", the applicant requested a copy of the sudden death report and raised complaints 1 and 2. She also referred to a discrepancy in the time her husband was said to have been found dead.

Strathclyde Police treated the applicant's letter as a request for information under the Freedom of Information (Scotland) Act 2002 ("the 2002 Act"). On 8 March 2006, Inspector J wrote to the applicant declining her request for a copy of the sudden death report. However, Inspector J provided the applicant with certain of the information contained within the report. On 11 May 2006, the applicant wrote to Strathclyde Police seeking a review of the decision not to supply her with a copy of the report. On 6 June 2006, she wrote a further letter to Strathclyde Police seeking information as to how Person A had died of coronary thrombosis.

The applicant contacted Strathclyde Police again by letter of 25 July 2007 stating that she had not heard anything from Chief Inspector E regarding her complaint. It is apparent from this and other correspondence that during 2006 and 2007 the applicant was in contact with Chief Inspector E, mainly in relation to the refusal to provide her with a copy of the sudden death report under the 2002 Act. In her letter of 25 July 2007, the applicant refers to four meetings she had arranged with Chief Inspector E which did not proceed. According to her letter, she herself had cancelled one of the meetings and Chief Inspector E had required to cancel the other three. The applicant stated that she had left messages with Strathclyde Police but no one had replied to these. In a document headed "My Statement" enclosed with her letter of 25 July 2007, the applicant reiterated that Constable D had allegedly bullied her.

Chief Superintendent K acknowledged the applicant's letter on 14 August 2007, advising that a senior officer would be in touch with the applicant. On the same date, an internal memo was sent from Chief Superintendent K to the officer in charge of the Force Disclosure Unit. In the memo, Chief Superintendent K suggested that because of Chief Inspector E's previous contact with the applicant in connection with her request for information, "it may be possible for him to provide explanation to her due to his knowledge of the circumstances." A handwritten note at the foot of this memo confirms Chief Inspector E's extensive contact with the applicant regarding her request for information. The note also refers to the cancellation of a previous meeting between the applicant and Chief Inspector E and states that he would make contact with her to discuss matters.

On 28 September 2007, the applicant wrote again to Strathclyde Police advising that, despite Chief Superintendent K's letter of 14 August 2007, she had not heard anything further. The applicant's letter contains a handwritten note by Superintendent L, date-stamped 2 October 2007, advising that Chief Inspector E was making arrangements to meet the applicant.

On 10 October 2007, Chief Inspector E wrote to the applicant confirming an appointment to meet with her near her home on 23 October 2007. Chief Inspector E advised the applicant that he hoped to be able to answer any questions she had about Person A's death and explain fully to her the procedure followed in reporting the matter to the Procurator Fiscal.

It is clear from a letter the applicant sent to Strathclyde Police dated 15 November 2007 that the meeting arranged for 23 October 2007 went ahead as planned. However, there is nothing within Strathclyde Police's files detailing what was discussed at the meeting. In her letter of 15 November 2007, the applicant disputes what Chief Inspector E apparently told her at their meeting. Specifically, she asked why Person A had not been taken to hospital given the information (within the death certificate) that he was found dead within an hour of finishing a performance. The applicant also referred to the apparent contradiction between the document issued by the Procurator Fiscal's office on 2 July 2001 (which stated that there had been a post mortem) and other information the applicant had received (stating that there had been no post mortem). She alleged that correct procedure had not been followed in relation to Person A's death and stated her belief that he had not died of natural causes. The applicant believed that there should be "a further investigation or an inquest".

On 3 December 2007 Chief Inspector E wrote to the applicant expressing his regret that he had been unable to explain to her satisfaction the circumstances of Person A's death. Chief Inspector E advised that her comments would now require to be dealt with as a formal complaint about the police. He explained that the first step in this process was to obtain a statement from her detailing her areas of dissatisfaction.

Chief Inspector E thereafter met with the applicant on 18 December 2007 and obtained a statement from her. A complaint about the police (CAP) form was completed which described the applicant's complaints as having been received on 18 December 2007. The complaints are categorised in the CAP form as "oppressive conduct/ harassment" and "corrupt practice" and are described as follows:

*"Conspire together to pervert the course of justice by failing to properly investigate the full circumstances of sudden death of the [applicant]'s late husband and conceal circumstances of death. Treat [the applicant] in oppressive manner."*

On 7 January 2008 the applicant wrote to Chief Inspector E, again referring to the apparent discrepancy in the time of Person A's death. The applicant stated that Chief Inspector E had specified this as "2.30 pm on Saturday" (16 June 2001) which was different from the time specified in the death certificate (11 pm on 15 June 2001).

On 18 February and 23 May 2008 the applicant wrote further letters to Chief Inspector E stating that she had heard nothing from him since she provided her statement on 18 December 2007.

On 27 June 2008, Chief Inspector E wrote to the applicant confirming that "as previously indicated" he would meet with her on 2 July 2008 to provide her with an update on his enquiries. Chief Inspector E also arranged for an officer from the Coroner's Court to attend the meeting to explain the procedures for the investigation of sudden deaths in England and to answer any questions she had.

Chief Inspector E obtained a further statement from the applicant on 2 July 2008. There is no record in the complaints file of Chief Inspector E's update to the applicant on his enquiries.

On 7 July 2008, Chief Inspector E wrote to the applicant expressing once more his regret that he was unable to resolve her concerns. He reiterated that the matter would now be dealt with formally as a complaint about the police and would be reported to the Complaints and Discipline Branch of Strathclyde Police in the following few weeks. It is apparent from Chief Inspector E's letter that during the meeting of 2 July 2008 the applicant claimed that Person A's death was not investigated properly.

The final communication between Chief Inspector E and the applicant was his letter to her on 8 August 2008, informing her that he had submitted his report on her complaints.

A preliminary report was submitted to the Area Procurator Fiscal on 18 August 2008 who, on 27 August, responded to Strathclyde Police as follows:

*"There is no evidence of criminality or any other crime and I therefore consider this is not an allegation from which it may reasonably be inferred that a police officer has committed a criminal offence and I therefore refer the matter back to you for such action as you consider appropriate."*

On 18 September 2008, Chief Superintendent M wrote to the applicant in response to her complaints. He informed her of the Area Procurator Fiscal's decision and advised that, in light of this, her allegation would be treated as non-criminal.

## The Commissioner's Review

The applicant first contacted the Commissioner's office by telephone in May 2007. She thereafter submitted an application form with various enclosures in July 2007. On contacting Strathclyde Police on 17 July 2007, the Commissioner's office was informed that no formal complaint had been lodged by the applicant. In November 2008, the applicant contacted the Commissioner's office again and a request was thereafter made to Strathclyde Police for its complaint file. This was received by the Commissioner's office on 18 December 2008.

Following a detailed examination of the information provided by the applicant and Strathclyde Police, the Commissioner considers that complaints 2, 3 and 4 listed above are beyond his statutory remit and cannot be included in his review. Complaint 2 alleges that there was a failure by Strathclyde Police to hold a post mortem following Person A's death. However, in Scotland the decision as to whether a post mortem is held is one solely for the Procurator Fiscal, not the police. Accordingly, complaint 2 is one that ought to have been directed to the Crown Office and Procurator Fiscal Service. Unfortunately, this was not communicated by Chief Superintendent M in his letter of response to the applicant, despite the fact that Chief Inspector E made it clear in his report.

In respect of complaint 3 (alleged discrepancy in the time of Person A's death), again it does not appear to the Commissioner that this is a complaint about the police. Entries in the Register of Deaths are created using details contained within the Medical Certificate Cause of Death ("the MCCD") prepared by the Police Surgeon. Accordingly, it appears that any complaint about a discrepancy in the recorded time of death should be directed either to the Casualty Surgeon (or his professional body) or the local Registrar's office. Only where it could be shown that the discrepancy may have arisen from a deficiency in the police investigation would this give rise to a legitimate complaint about the police. As the MCCD is no longer available, it is not possible to say whether the discrepancy arose from such a deficiency.

With regard to complaint 4 (alleged failure to pass Person A's body to the Coroner for a post mortem), again any decision in this connection would be one for the Procurator Fiscal rather than the police. Accordingly, this is not a legitimate complaint about the police. Chief Inspector E reached the same conclusion in his report, but again this was not communicated to the applicant in the written response to her complaints.

The Commissioner has included complaint 1 (alleged bullying by Constable D) in his review. With regard to complaint 5 (alleged failure properly to investigate Person A's death) the applicant alleged that this was an example of an underlying conspiracy in relation to Person A's death. Accordingly, Strathclyde Police initially treated complaint 5 as a criminal complaint about the police and referred the matter to the Area Procurator Fiscal. In terms of section 34(3)(b) of the Act, the Commissioner has no power to deal with complaints about the police which consist of an allegation of an act which constitutes a crime. As noted above, the Area Procurator Fiscal has already decided that there is no evidence of criminality in respect of any of the applicant's complaints.

Given that complaint 5 is, in essence, a non-criminal complaint, and that the Area Procurator Fiscal has decided that there is no evidence of criminality, the Commissioner has decided to include consideration of it within his review.

The remainder of this section sets out the Commissioner's views on the manner in which complaints 1 and 5 were handled by Strathclyde Police. Each complaint is set out in turn and is followed by details of how Strathclyde Police handled it and the Commissioner's views on this.

## Complaint 1: Constable D's alleged bullying behaviour

The applicant's letter to Strathclyde Police of 9 February 2006 contains the following passage:

*"[Constable D] rang me twice and confused me. He was saying my husband had a post mortem, then he rang me again, this time he told me off. He was saying it's dragging on, there's only a certain amount of space, I'm just helping you, you better do it in [the applicant's home town]. So I asked the Constable what to do and he said to contact the undertaker. I was so upset and worried, I lost my confidence and I was overwhelmed with fear."*

The following passage is quoted from the applicant's statement of 18 December 2007:

*"I feel that [Constable D] bullied me when he was speaking to me on the telephone. To begin with he was really nice but by the end he was raising his voice. All of the conversations happened within a week of my husband's death, but I don't [recall] the dates or times. The first time he called me to say that the Procurator Fiscal would investigate my husband's death. About two days later he called me back ... He told me that the Procurator Fiscal had finished his investigation. He told me my husband died of a heart attack and that there would be no post mortem. He also told me that other musicians had said my husband had pains in his arms on the days before he died and had told other musicians. [Constable D] said my husband's death wasn't suspicious and that distressed me. I was really upset and because of this [Constable D] told me he was going to get the Procurator Fiscal to ring me. I told [Constable D] that I was unhappy that there was no Post Mortem (Autopsy) and I said I would like one. He said I should contact my Doctor."*

### Internal Handling

In his report, Chief Inspector E detailed the accounts provided by the applicant and Constable D. In respect of Constable D's position on the matter, the report contains the following passage:

*"He cannot recall the times or dates of the conversations but recalls that the [applicant] did ask for information about how she would go about arranging an autopsy [in Scotland]. Constable [D] states that he provided a telephone number for the Procurator Fiscal and advised [the applicant] to make contact with them.*

*Constable [D] denies that he advised the [applicant] not to pay for an autopsy and states that he could not make comment on surgery space as he would be unaware of this. He cannot recall the conversation specified by [the applicant] but states that during all of his conversations with her he was polite and helpful. He denies the allegation of oppressive conduct."*

Chief Inspector E reached the following conclusion:

*"In essence there is no evidence to support the allegation ... Constable [D] asserts that in all telephone conversations with the [applicant] he was polite, courteous and helpful. This position is supported by the allegation that [he] indicated there was no surgery space available [locally] where an autopsy could be performed, to which Constable [D] states that he would not have sufficient knowledge to make such a comment."*

In his response to the applicant, Chief Superintendent M stated

*"You told Chief Inspector [E] that in the course of one particular telephone conversation with the Officer he was aggressive and attempted to bully you into abandoning a particular course of action. Chief Inspector [E] found no evidence to support your point of view. The Officer concerned was interviewed and denied that he behaved as you suggested,*

*therefore in the absence of any additional evidence I find that this allegation is not substantiated.”*

### Consideration

Given that Constable D denied the allegation, it is not surprising that Strathclyde Police found this complaint to be unsubstantiated. In the Commissioner's view, Strathclyde Police carried out satisfactory enquiries into this complaint and reached a reasonable conclusion based on the available evidence.

However, this complaint was first made to Strathclyde Police in the applicant's letter of 9 February 2006. As noted above, the complaint was not identified by Strathclyde Police at that time and the applicant's letter was treated solely as a request for information under the 2002 Act. Indeed, it appears that this complaint was not formally identified by Strathclyde Police until 18 December 2007 when the applicant provided a statement and a CAP form was completed.

The Commissioner considers that substantively this complaint was adequately investigated and a reasonable response issued based on the evidence. However, at a procedural level there was a clear failure to identify and record the complaint when it was first made in February 2006. Indeed, despite the applicant raising the complaint again with Strathclyde Police in July 2007 it was not until December of that year that it was formally recorded as a complaint about the police. In light of these deficiencies the Commissioner considers that, overall, this complaint was not handled in a reasonable manner.

### Complaint 5: Alleged failure to investigate Person A's death

In her statement dated 18 December 2007 the applicant stated the following:

*“I would also like to complain that my husband was murdered. I think he was murdered because he was playing his trumpet an hour before he was supposed to have died. How can this happen? He also spoke to me on the phone about ... two days before he died. He didn't say he wasn't feeling well at all ... I have been told by Chief Inspector [E] that other musicians in the band said he was missing notes and complaining of pains in his arms the day that he died. He never told me that. I am aware that my husband had High Blood Pressure and Hypertension and had been on medication for over a year ...*

*The other thing I think makes it suspicious is that the death certificate says he was found in a caravan. That is not true. My husband slept in a bunk wagon not a caravan... I have been shown the Sudden Death Report that the police sent to the Procurator Fiscal and it does say that my husband was found dead in the bunk wagon. Chief Inspector [E] has suggested to me that this is just wrongly recorded but I don't accept that...*

*The other reason I think he was murdered was because I found an entry in his diary about two weeks before died ... In it my husband says that [another band member] was (Mental) and lost his temper quickly ... My husband never said the [band member] ever assaulted or threatened him ... I think the [band member] or another musician may have had something to do with my husband's death. I have no evidence or proof but I think it is possible.*

*... Strathclyde Police didn't investigate my husband's death.”*

In her statement of 2 July 2008, the applicant states the following:

*“I would also like to add that the exerts [sic] from my husband's journal talk about [the location of circus camp] being a very rough area so maybe something happened to him. In his diary for 3 June 2001, he also says that there was a fire in the driver's cab of the bunk wagon. Maybe this had something to do with his death. I don't know.*

*... In my earlier statement I said that I thought my husband was murdered but that I didn't have any evidence of that. I don't know for certain that he was murdered so I can't say that, but I believe he didn't die of natural causes...*

### *Internal Handling*

Chief Inspector E noted in his report that the applicant based this complaint on "a number of specific aspects of investigation into the death of her late husband which she alleges were highly irregular and did not conform to what she believes were the correct procedures."

As part of his enquiries Chief Inspector E obtained statements from Constables B, C and D. His report contains the following passage:

*"As can be seen from their statements [Constables B and C] maintain that the death of [Person A] was properly investigated by them and that the circumstances of the death were entirely non-suspicious. Constables [B and C] assert that all reasonable steps were taken by them to investigate the death, including the examination of the body of the deceased and the interview of all relevant witnesses."*

With regard to Constable D's recollections, Chief Inspector E noted the following:

*"He states that he would have made a number of enquiries in an effort to finalise the information required for the Sudden Death Report but cannot recall the exact details of the enquiries undertaken. Constable [D] confirmed that there appeared to be no suspicious circumstances ..."*

Chief Inspector E went on to state the following in his report:

*"Each of the aspects of investigation into the death of her late husband which the [applicant] alleges was highly irregular and did not conform to what she believes were the correct procedures can be satisfactorily explained. Indeed during his meetings with her, the reporting officer has spent considerable time attempting to explain the reasons for the actions of the police and others during the investigation and attempting to explain the discrepancies within specific documents..."*

*In relation to the entry at field 8 (Where died) on the Extract of the Entry in the Register of Deaths, dated 22 June 2001, the operational statements of the officers concerned and the Sudden Death Report correctly identify and describe a cabin within the bunk wagon used by workers from the [circus company]. Within [Doctor Z]'s report, this is recorded as a caravan and is likely to have been similarly recorded on the Medical Certificate of Cause of Death, although this cannot be confirmed as [it] has been destroyed by the Registrar ... in line with their authorised retention policy. The likely explanation for this discrepancy is, therefore, a difference in the terminology used to describe the accommodation used by the deceased, as a number of similar descriptions would also apply to this accommodation.*

*There is no evidence which supports the allegations which the [applicant] has made based upon the information contained in her late husband's writings and journal. While the [band member] is described as having a short temper no information is recorded to indicate that he ever assaulted the deceased or any other person within the Circus. In addition the examination of the body of the deceased by [Doctor Z] and Constables [C and D] revealed no marks, scars or other injuries consistent with the deceased having been assaulted. Likewise the entries in the deceased's journal describing [the location of the circus camp] make only observations on these areas and no other information was uncovered during the initial police investigation to indicate that these entries are of any significance. Similarly, the entry in the deceased's journal which makes reference to an earlier fire within the bunk*

*wagon did not feature during the initial police investigations and it is worthy of note that at the time of the deceased's death no other occupants reported any illness consistent with such an event. Indeed, the initial police investigations excluded carbon monoxide poisoning... on the grounds that there was sufficient ventilation and the post-mortem lividity on the body of the deceased was not consistent with asphyxiation ...*

*In the course of investigating this complaint the reporting officer has obtained the appropriate operational statements from the police officers concerned ... The police officers' statements have been completed to the best of their recollection, however, given the passage of time a number of specific pieces of information cannot be provenanced."*

Chief Superintendent M responded to this complaint as follows:

*"... I am aware that you have had several meetings with Chief Inspector [E] ... who travelled to [the applicant's home town] to discuss issues of concern to you relative to the investigation. On the basis that Chief Inspector [E] has discussed the issues with you at some length, and noting that you agree he has done so, I do not intend to cover the various points in detail in this letter. I can tell you that I have carefully reviewed Chief Inspector [E]'s report and I am absolutely satisfied that a proper investigation was conducted in the circumstances of your husband's death, that a sound conclusion was reached and that no conspiracy has occurred. Therefore I conclude that this allegation is not substantiated."*

### Consideration

In the Commissioner's view, Chief Superintendent M did not adequately address this complaint in his letter. In essence, Chief Superintendent M's response amounts merely to an assurance that Person A's death was properly investigated. It did not address any of the issues raised by the applicant which, according to her, support the view that Person A's death was not properly investigated. This is despite the fact that Chief Inspector E dealt with each issue in detail in his report.

Although it appears that many of Chief Inspector E's findings were discussed with the applicant during the course of their various meetings, the Commissioner also does not consider it satisfactory for the written response to this complaint simply to have referred to those previous meetings. This is particularly so given that there is no formal record within the police file of what was discussed at those meetings. In the Commissioner's view, Strathclyde Police ought to have provided a fully reasoned, written response to this complaint.

Accordingly the Commissioner does not consider that this complaint was handled in a reasonable manner. In the circumstances, however, the Commissioner considers that the details of Chief Inspector E's report quoted above are sufficient properly to inform the applicant of the outcome of her complaint.

### Conclusions, Recommendations and Learning

It is clear that Chief Inspector E spent a great deal of time and effort explaining to the applicant in person the procedures which were followed by the police following the death of Person A. Chief Inspector E offered the applicant the opportunity to have a variety of documents translated into her native language and an interpreter was employed during the meetings. Chief Inspector E even arranged for a representative of the Coroner's Court to attend one of the meetings to explain the procedures applicable in England and Wales. It is unfortunate that despite these genuine and sincere efforts the applicant remained sufficiently concerned to pursue formal complaints about the police. In the Commissioner's view, taking into account the time which had elapsed since Person A's death, Chief Inspector E's subsequent enquiries into the complaints were thorough and comprehensive.

However, there were also clear deficiencies in the handling of the applicant's complaints. As noted above, despite the fact that it included complaint 1, the applicant's initial letter to Strathclyde Police of 9 February 2006 was treated purely as a request for information under the 2002 Act. In the event, that complaint was not formally recorded by Strathclyde Police until 18 December 2007. It also appears from Strathclyde Police's file that between December 2007 and the conclusion of Chief Inspector E's enquiries in July 2008, a number of letters sent by the applicant in which she sought information about progress went unanswered.

In light of these deficiencies, and the lack of a properly reasoned final response to complaint 5, the Commissioner recommends that Strathclyde Police apologise to the applicant.

The Commissioner wishes to make clear, however, that his conclusions in respect of complaint 5 relate solely to the manner in which they were handled, and not to their substance. In the Commissioner's view, there is nothing in the points raised by the applicant to justify her conclusion that Person A's death was not investigated properly at the time.

### **Complaint 1: Constable D's alleged bullying behaviour**

For the reasons given, the Commissioner does not consider that this complaint was handled in a reasonable manner.

### **Complaint 5: Alleged failure to investigate Person A's death**

For the reasons given, the Commissioner does not consider that this complaint was handled in a reasonable manner.

### **Learning Points**

(1) As noted above, Strathclyde Police's complaints file contains no formal record of the discussions that took place between the applicant and Chief Inspector E. It is clearly important that auditable records are kept of all enquiries undertaken in complaint cases. This is an issue which the Commissioner has raised in a number of complaint handling reviews and which he intends to monitor.

(2) Where enquiries into complaints become extended, applicants should be issued with regular, written updates informing them of the current status of their cases.

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