Joanne Caffrey Expert Witness

For Safer Custody, Police Procedures and Use of Force

Email: [redacted]

Expert Witness Report

Re: Mr Sheku Bayoh (Deceased)

By Joanne Caffrey, Total Train Ltd

Date of incident: 3rd May 2015

Date of report: 31st October 2022

Prepared at the request of:

The Public Inquiry into the death of Sheku Bayoh

Caveat: The opinions expressed in the following chapters are based on the evidence and information available to me as at the date of this report. Should further relevant evidence or information become available, I may require to reconsider my opinions.

Index

1. Background

1.1 As provided to me:

The Inquiry will establish the circumstances surrounding the death of Sheku Bayoh in police custody on 3 May 2015.

Overview. Unless stated otherwise, the facts set out below are not contentious:

- 07:20:23 – PCs Walker and Paton arrive at locus. PC Walker discharged PAVA spray; PC Paton discharged CS spray; the spray had no effect on Mr Bayoh but both officers were (temporarily) incapacitated
- 07:20:39 – PCs Tomlinson and Short arrive at locus. PC Tomlinson discharged CS spray; PC Short swung her baton but did not make contact with Mr Bayoh
- 07:21:02 – PC Paton transmits, "officer's injured, PC Short male…"
- 07:21:03 – CCTV footage appears to show a person falling to the ground
- The Inquiry has heard evidence that Mr Bayoh struck PC Short on the back of her head, causing her to fall to the ground[1]. The key dispute here is whether Mr Bayoh then stamped on her back, per the evidence of PCs Walker and Tomlinson. PC Short has no recollection of this; an eye witness, Kevin Nelson, says it did not happen. It will be for the Chair to determine whether or not Mr Bayoh stamped on PC Short's back. We will invite you to consider two hypotheses of fact in your report: (i) that Mr Bayoh did stamp on her back; and (ii) that he did not stamp on her back
- (precise time unknown) – PC Tomlinson strikes Mr Bayoh on the head with his baton, more than once. PC Tomlinson's evidence was that this was in response to Mr Bayoh stamping on PC Short (which is in line with hypothesis (i) above); in relation to hypothesis (ii), proceed on the basis that this strike with a baton occurred in response to the blow to the head of PC Short only

[1] Please note that Sgt Maxwell's transmission at 7:26:52 – "on attendance this male's attacked PC Short quite violently er as a result he was sprayed with CS and PAVA and batoned" is incorrect: there is no dispute that Mr Bayoh was sprayed with CS and PAVA *before* he struck PC Short.

- (precise time unknown) – PC Walker takes Mr Bayoh to the ground and the restraint begins. PC Walker described shoulder charging Mr Bayoh; PC Tomlinson described the mechanism by which PC Walker took Mr Bayoh to the ground as a "bear hug"
- 7:21:13 – it appears from the CCTV that Mr Bayoh was on the ground by this time
- 7:21:19 – PC Tomlinson's emergency button is activated. PC Tomlinson gave evidence that by the time he pressed his emergency button, Mr Bayoh was on the ground
- 7:21:38 – PC Smith transmits, "male secure on the ground"
- 7:22:24 – PC Walker transmits, "male in cuffs still struggling"
- The first officer to restrain Mr Bayoh was PC Walker. He was quickly joined by PC Tomlinson, then PC Paton, then PC Smith, then Constables Gibson and McDonough, and finally Constable Good
- The majority of police and civilian eyewitnesses gave evidence that Mr Bayoh was in the prone[2] position until the point that he was turned onto his side, at which time the officers noted he was unconscious and PC Smith sought an ambulance (07:25:17) (see below). PC Walker (supported to some extent by PC Paton) states that he was on his back throughout. Again, we will seek your views on two hypotheses of fact: (i) that Mr Bayoh was prone throughout the restraint, until he was turned onto his side; and (ii) that Mr Bayoh was on his back throughout the restraint until he was turned onto his side
- 7:25:17 – PC Smith transmits, "this male now certainly appears to be unconscious, breathing, not responsive get an ambulance for him". By this time, handcuffs and leg restraints had been applied
- 7:29:30 – Sgt Maxwell transmits, "this accused is now not breathing, CPR is commencing"
- 7:33:35 – ambulance arrives at locus

[2] That is to say, on his front (as opposed to his back or side). You will note that the witnesses who gave evidence that Mr Bayoh was prone gave various descriptions of his precise position and the extent to which that position changed during the course of the restraint.

The hypothetical reasonable officer

The standard against which the officers' actions and omissions will fall to be assessed by the Chair is that of an officer acting in accordance with the law, their training, Standard Operating Procedures, their ethical obligations, and any other guidance available to them. In the questions that follow, I shall refer to this hypothetical officer as the "reasonable officer", by way of shorthand.

Our law and practice note provides a synopsis of the applicable law. Read short, it amounts to this:

- an officer is entitled only to use force that is reasonable, proportionate and (the minimum) necessary
- the principle of "preclusion" dictates that less forceful options must have been attempted and failed, or have been considered and found to be inappropriate in the circumstances

As mentioned above, the training materials used in 2015 will be made available to you, along with the guidance in place at that time

2 Instructions

2.1 I would be grateful if you could provide your opinion on the following issues (this list is not exhaustive; please offer a view on any other matters that are within your expertise and which you consider to be relevant):

Question 1. Management of the Incident: Command and Control

Please note that a critical incident was declared by Chief Superintendent Gary McEwan at approximately 09:10, upon learning of Sheku Bayoh's death.

- In light of the information known to the ACR (terror threat level; date and time of call; 999 and 101 calls), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public?
- Would you expect an ACR in Edinburgh to be able to access local information about a locus in Kirkcaldy (in particular, whether the area was residential or commercial; proximity to hospitals, churches etc)? If so, how would this information be accessed? When would you expect these enquiries to be made?
- If not, would you expect a reasonable ACR Inspector to make; be making or have made, appropriate enquiries from the response team or others as to the nature of the locus? When would you expect these enquiries to be made?
- What conclusion would a reasonable ACR Inspector have reached as to the likely risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public; and why?
- How would that assessment inform a reasonable ACR Inspector's decision making in terms of (i) the categorisation of the incident, (ii) the resources to be allocated to the incident, and (iii) the ongoing management of the incident?
- How would a reasonable ACR Inspector have categorised the incident (in particular: Grade? Firearms? Critical?); and why? When would a reasonable Inspector have taken this decision vis-à-vis the arrival of the response team?

- What resources would a reasonable ACR Inspector have deployed to the incident and why?
- In your opinion, would a reasonable ACR Inspector require feedback from response officers dispatched to the locus in order to complete his assessment as to the appropriate categorisation of the incident, and the resources and management it required? How long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? How long would a reasonable ACR Inspector take to implement any such steps?
- If response officers were already en route to the locus by the time a reasonable ACR Inspector learned of the incident, how long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? In the absence of any feedback, how long would a reasonable ACR Inspector take to implement any such steps?
- What directions, if any, would he have given to those officers and when?
- (Depending on your view as to how a reasonable ACR Inspector would have categorised the incident as firearms, critical etc) What procedures and steps would then have been implemented to manage the incident?
- Please describe the roles and responsibilities of the various personnel who would have been involved in the command and control of the incident, with particular reference to (i) the ACR; (ii) senior officers within Fife Police and Kirkcaldy Police Office; and (iii) individual response officers.
- In your opinion, had the incident been declared a firearms incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a firearms incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).
- In your opinion, had the incident been declared a firearms incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a firearms incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).

- In your opinion, had the incident been declared a critical incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a critical incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).

Question 2. Risk assessment:

2(a) En route to the locus

- In light of the information known to the attending officers (airwave transmissions; terror threat level; day and time of call; proximity of locus to residential area, hospitals etc), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- What conclusion would a reasonable officer have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- Why?
- How would that risk assessment inform the available tactical options?

2(b) First officers at locus: Constables Walker and Paton

- In light of the information known to Constables Walker and Paton (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- What conclusion would a reasonable officer, arriving first at the scene, have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- Why?
- How would that risk assessment inform the available tactical options?

2(c) Second officers at locus: Constables Tomlinson and Short

- In light of the information known to Constables Tomlinson and Short (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- What conclusion would a reasonable officer, arriving second at the scene; have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
- Why?
- How would that risk assessment inform the available tactical options?

Question 3. Initial contact

3(a) Constables Walker and Paton arrive at the locus

- Please categorise Mr Bayoh's offender behaviour[3] at the time of the officers' arrival at the locus
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response[4] was appropriate?
- What tactical options were open to a reasonable officer?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?

[3] Chapter 4.6 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a))1 compliance; 2 verbal resistance and/or gestures; 3 passive resistance; 4 active resistance; 5 assaultive resistance; 6 serious/aggravated assaultive resistance

[4] Chapter 4.7 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a)) 1 officer presence; 2 tactical communications; 3 control skills; 4 defensive tactics; 5 deadly or lethal force

- On balance of probabilities, had that option been selected, what difference might that choice have made?
- Please categorise[5] and comment on the response(s) by Constables Walker and Paton at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer
- On Day 20, 21 June 2022, at page 91 to 94 inclusive, Constable Paton addressed in his evidence the possibility of an alternative course of action, namely parking in Gallagher's Pub car park, waiting for an Armed Response Unit, observing and monitoring Sheku Bayoh and providing feedback to the Area Control Room and airwaves transmissions to other officers on route. We invite your comments on this possible alternative course.

3 (b) Constables Tomlinson and Short

- Please categorise Mr Bayoh's offender behaviour at the time of the officers' arrival at the locus
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- In light of the apparent actions already taken by Constables Walker and Paton, what tactical options were open at that stage to a reasonable officer arriving at the scene?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?
- On balance of probabilities, had that option been selected, what difference might that choice have made?

[5] See footnote 4

- Please categorise and comment on the response(s) by Constables Tomlinson and Short at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer

Question 4. Assault of Nicole Short

Question 4 Hypothesis 1: punch to back of head (no stamp)

- Please categorise Mr Bayoh's offender behaviour at the time of the assault
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- What tactical options were open to a reasonable officer?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?
- On balance of probabilities, had that option been selected, what difference might that choice have made?
- Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer

Question 4 Hypothesis 2: punch to back of head, followed by stamp(s), as demonstrated by Constables Walker and Tomlinson in their evidence

- Please categorise Mr Bayoh's offender behaviour at the time of the assault
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- What tactical options were open to a reasonable officer?

- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?
- On balance of probabilities, had that option been selected, what difference might that choice have made?
- Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer

Question 5. Restraint - taking Mr Bayoh to the ground

- Please categorise Mr Bayoh's offender behaviour at the time he was taken to the ground
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- What tactical options were open to a reasonable officer ?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?
- On balance of probabilities, had that option been selected, what difference might that choice have made?
- Please categorise and comment on the response by Constable Walker. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer
- Please comment on the manner in which Constable Walker took Mr Bayoh to the ground (i) on the hypothesis that he "shoulder charged" Mr Bayoh to the ground and (ii) on the hypothesis that he took Mr Bayoh to the ground in a "bear hug"

6. Restraint: position of Sheku Bayoh; duration; number of officers involved; use (and position) of force and bodyweight applied to Sheku Bayoh

Question 6 Hypothesis 1: prone restraint

- Please categorise Mr Bayoh's offender behaviour during the restraint
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- What tactical options were open to the officers involved in the restraint (i) initially, and (ii) as the restraint progressed?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?
- Why?
- On balance of probabilities, what difference might the choice of that tactical option(s) have made?
- Please categorise and comment on the response by the officers. In particular, indicate to what extent, if any, their response differed to that of a reasonable officer or officers

Question 6 Hypothesis 2: supine restraint

- Please categorise Mr Bayoh's offender behaviour during the restraint
- What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?
- What level of response was appropriate?
- What tactical options were open to the officers involved in the restraint (i) initially, and (ii) as the restraint progressed?
- Please identify all factors relevant and material to your assessment of the option(s) available
- What option(s) would a reasonable officer have chosen?

- Why?
- On balance of probabilities, what difference might the choice of that tactical option(s) have made?
- Please categorise and comment on the response by the officers. In particular, indicate to what extent, if any, their response differed to that of a reasonable officer or officers

Question 7. Restraint: general

We invite your comments on:

- The length of the restraint
- The number of officers involved in the restraint at different stages of the restraint
- The force applied to Mr Bayoh as he lay on the ground, insofar as you are able
- PC Paton's use of a baton during the restraint
- By reference to the enhanced Snapchat footage and stills from same; the evidence (which is in dispute) that Constable Walker (who weighed 25 stones) lay across Mr Bayoh's back
- The evidence (from a number of witnesses) that the restraint bore resemblance to a "collapsed rugby scrum"
- Whether a reasonable officer would have monitored or arranged to have monitored, Mr Bayoh's breathing during the restraint
- The significance of environmental factors (weather, temperature, Mr Bayoh's state of dress)

Question 8. Miscellaneous

Insofar as not already explored within the answers to preceding questions, please comment on the following:

- Waiting and observing;
- De-escalation: please describe de-escalation techniques and explain what they are designed to achieve and the possible outcomes when such techniques are employed;
- Acute Behavioural Disturbance/Excited Delirium/mental health crisis[6]: please offer a view as to how these matters were defined/taught to officers in 2015; a view as to how these may have been recognised by officers in the field; and whether any of the evidence indicated that Mr Bayoh displayed any signs or symptoms of ABD/ED/mental health crisis (drug induced or otherwise). If so: whether a reasonable officer would have had in mind the possibility of ABD/ED/mental health crisis; at what point in time would this possibility have crossed his mind; and what action would he have taken;
- Positional asphyxia[7]: describe what a reasonable officer would have known of this risk in 2015; describe the steps a reasonable officer would have taken to mitigate the risk of positional asphyxiation (i) if Mr Bayoh were restrained in the prone position and (ii) if he were restrained in the supine position; and
- In what circumstances (if any) do you consider it would be appropriate for an officer to strike a suspect with a vehicle on arrival at a scene? Please refer to the evidence of PC Walker on Day 6, 19 May 2022 page 39, line 22; pages 64 line 23 to page 66 line 8. Please categorise and comment on this proposed response by an officer. In particular, indicate to what extent, if any, this response would differ to that of a reasonable officer or officers.

[6] See Chapter 5 and 21.3 of the Use of Force SOP (PS10933); pages 23-25 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual PS11538(a))
[7] See Chapter 21 of the Use of Force SOP (PS10933); pages 26 and 27 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual (PS11538(a)

3 Expert Witness' Background to provide opinion

My CV is at Appendix N of this report.

3.1 I have been engaged for approximately 150 case reports over the last 5 years concerning deaths or injuries in custody, police custody procedures and use of force within all of the secure custody sectors. Additionally, I have provided initial email opinions and conference calls.

3.2 I have provided reports for misconduct cases, coroner inquiries, fatal accident inquiries, civil and criminal cases. I have given evidence in coroner court, fatal accident inquiries, civil and criminal cases (Magistrates and Crown Court). My reports have been accepted for police misconduct cases. The approximate split of cases is as follows:

- Defence: 38%
- Prosecuting Authority/Claimant: 56%
- Engaged directly by the coroner: 6%

3.3 I have been engaged by legal defence teams representing Police Custody Sergeants and Police Constables for misconduct and criminal cases.

3.4 My length of service was 23.5 years and a summary of my expertise includes:

> **3.4.1** Performing as an operational officer from 1990, a Police Support Unit (PSU) Sergeant, a patrol Sergeant and a custody Sergeant in Cumbria Constabulary. I was an acting Sergeant in 1996 until 2003 inclusive when I transferred to Police Headquarters Sergeant roles. I deployed between the operational Sergeant roles as required. The PSU role was on 'call out' or pre planned events deployment, or as a temporary PSU Sergeant for approximately 3 months when the existing PSU Sergeant performed as an acting Inspector.

3.4.2 I have been trained in police use of force annually since 1990 until leaving Cumbria Constabulary in 2013. I trained as a PSU (Police Support Unit)[8], often referred to as 'task force' Sergeant, to the UK mutual-aid standards for use of force. Since 2012 I have been qualified as a civilian use of force instructor. This qualifies me to deliver use of force training in any UK setting.

3.4.3 Being head of specialist training for Cumbria Constabulary which included custody, use of force, and first aid training. I recall my time within the training department as being 2004 to 2007 inclusive.

3.4.4 Being the lead trainer for custody training in Cumbria Constabulary, teaching PACE, Safer Detention and intoxyliser procedures. This was 2006 and 2007 whilst also being head of the specialist training team and blending the use of force and first aid into custody training scenarios.

3.4.5 In 2006 I designed the first 'Safer Detention and Handling of Persons in Police Custody' (SDHP) training course, which was adopted by the National Police Improvement Agency (Training) for national roll-out.

3.4.6 For my custody training and national consultancy, I received senior officer awards. I was National Policing Improvement Agency (NPIA) commended in their 2008 Peer Review of the Constabulary. In 2010, I received an Assistant Chief Constable (ACC) award for custody training, and in 2012 I received the British Association of Women in Policing (BAWP) excellence in performance award, presented by Dame Cressida Dick for custody training and other services.

3.4.7 I have conducted performance reviews of custody staff for their development and reviewed custody CCTV footage at the request of the Professional Standards Department for misconduct investigations which included use of force incidents.

3.4.8 I served within the Constabulary Emergency Planning Unit, designing plans and exercises for major incident management, and supervising 4 counter

[8] The Police Scotland Public Order SOP 2020 page 5 refers to PSUs: "For demonstrations, protects, incidents or events where there is a requirement for PO capability, PO trained officers must deploy and mobilise in a PSU." PO means Public Order. https://www.scotland.police.uk/spa-media/hutbybp5/public-order-sop.pdf

terrorism security advisors within the team. I delivered training to all ranks concerning Gold, Silver and Bronze commands for incidents. I recall the dates of this deployment as being 2008 to 2013 inclusive. I was also involved in the training of control room operators for Casualty Bureau management. This is part of the 'Command and Control' function for major and critical incidents, and is the central point where all information related to an incident is received, collated and assessed. The Casualty Bureau Incident Room provides resources and a process to manage high-volume data, in order for key or critical information to be identified at the earliest opportunity. The Casualty Bureau Incident Room provides a direct line for the public to report people involved in an incident. I was a Casualty Bureau room manager for a school bus crash which was declared a major incident and a critical incident in 2010. The Casualty Bureau function works alongside of the force control room.

3.4.9 Since leaving the police service, I have trained as an expert witness with Bond Solon and worked as an expert witness for custody matters involving police, prison and mental health facilities, which include the use of force.

3.4.10 I have been instructed and/or provided initial opinions for coroner court, civil, criminal and misconduct cases by legal teams representing police forces, police officers, and the members of the public.

3.4.11 I have been engaged by the Police Federation, the Independent Office for Police Conduct[9] (IOPC), and the Police Ombudsman Northern Ireland.

3.4.12 I have worked as an advisor to a 'Liberty' human rights group investigator concerning the use of force in immigration centres.

3.4.13 I was a civilian first aid instructor from 2012 to 2021 inclusive, which also involved restraint specific first aid training.

3.5 I am registered with, and vetted by, the National Crime Agency (NCA) as a major crime investigative support expert advisor for police custody cases.

[9] Formerly the Independent Police Complaints Commission (IPCC)

3.6 I am experienced in the training of the Code of Ethics/performance standards to Constables and Sergeants which has been a consistent theme within all of my police training. The Code of Ethics is incorporated into the National Decision-Making Model (NDM), which is used by Police Scotland and forces throughout England, Wales and Northern Ireland. All police procedures should incorporate the NDM along with the standards of professional behaviour and the policing principles.

3.7 I have published articles in the Expert Witness Journal magazine concerning use of force and deaths in custody. These include:

3.7.1 Winter 2018: 'Safer Custody, Police or Prison Establishments';

3.7.2 Autumn 2019: 'Managing Ligature Risks, Preventing Death by Hanging':

3.7.3 Winter 2020: 'Effects of Stress for Defence or Mitigation to Assault':

3.7.4 February 2021: 'Understanding De-escalation and Conflict Management to manage down the Use of Force';

3.7.5 October 2021: 'Drink and Drug Driving'; and

3.7.6 February 2022: 'Assaults on Emergency Workers'.

3.8 I have used custody chain-link, plasticuffs, patrol chain-link and rigid handcuffs over my career. Operational chain-link handcuffs were the predecessor of the current rigid cuff. The rigid bar was not present, instead there was a chain between the two cuffs. The cuffs were both of a single and double bar which interlocked. The custody chain-link handcuffs were large and heavy handcuffs joined by a chain which did not work on the principle of application to the wrist, and pressure to the wrist as a controlling device. The custody cuffs were commonly used for transportation between custody facilities and were withdrawn from service after the introduction of the 2006 Safer Detention guidance. Since 2012 I have been qualified as a handcuff instructor to deliver BTEC awards for safe use of handcuffs. BTEC is a Business and Technology Education Council qualification which is based upon a practical application of knowledge and skill. They are available as a recognised qualification throughout the UK. I have maintained my competency through annual instructor requalification until its expiry in March 2022. I am still qualified to deliver handcuff training, but I am not currently maintaining authority for claiming the BTEC

awards for students. I can still issue certificates of competency and claim Continuing Professional Development (CPD) points for handcuff training courses if required. I am a qualified instructor for limb restraints. I have used my police batons in real situations, the PR24 baton and the friction lock baton. I have carried CS but not discharged it. However, I have been involved in disorder where other officers have discharged their CS.

3.9 I am a qualified instructor for a variety of use of force topics. These include:

3.9.1 Conflict management and De-escalation;
3.9.2 Self-defence;
3.9.3 Close-quarter Combat;
3.9.4 Physical Intervention;
3.9.5 Handcuffs;
3.9.6 Soft-cuffs and Soft Restraints;
3.9.7 Emergency Response Belts; and
3.9.8 Security Industry Authority (SIA) Physical Intervention Skills.

3.10 I have been qualified as an instructor for delivering training concerning:

3.10.1 Mental Health First Aid.
3.10.2 Mental Health Awareness; and
3.10.3 Mental Capacity Act 2005 and Deprivation of Liberty.

These are via the accreditation body 'TrainerQuals' for delivery to healthcare sector staff.

3.11 I have designed, and had certified by OCN Credit 4 Learning and/or CPD UK, a variety of courses for UK wide delivery. OCN Credit 4 Learning is an accrediting organisation which supports providers who deliver training and educational programmes. They offer both full accreditation and Continuing Professional Development (CPD) points through learning credits mapped to national standards. CPD UK is an accreditation service for formal Continual Professional Development. They assess training courses against national standards and award CPD learner points. Both organisations annually

review my training company for membership renewal. I have annually renewed with OCN Credit 4 Learning since 2017 and with CPD UK since 2020.

Courses which I have certified include:

3.11.1 Managing Challenging Behaviour – 18 hours;
3.11.2 Restraint Specific First Aid module – 6 hours;
3.11.3 Managing the Use of Force – 6 hours;
3.11.4 Managing Head and Brain Injuries for Non-healthcare Staff – 6 hours;
3.11.5 Tactical Communication Skills – 6 hours; and
3.11.6 Suicide Prevention and Ligature Management – 18 hours.

3.12 I have trained Health Care Professionals (HCPs) for their role within a forensic custody environment which has included the assessments for:

3.12.1 Fitness to detain;
3.12.2 Fitness to interview;
3.12.3 Custody care planning;
3.12.4 Bail risk assessment; and
3.12.5 Working alongside police officers.

3.13 I have partaken in a review exercise with Oxford University Press who publish Blackstone's Custody Officers' Manual concerning the existing edition's update.

3.14 I have conducted and supervised, restraints, prone and supine positions, irritant spray use, limb restraints and the cell extraction/relocation techniques on numerous occasions. During custody officer training I have advised concerning risks and control measures. I have been part of a shield team for violent/deranged person cell entry.

3.15 I have regular experience of cases involving restraint injuries. My experience concerning restraint involved death cases includes:

3.15.1 SIA restraint death – Sainsbury's;

3.15.2 Police Ombudsman Northern Ireland – death following police custody unit restraint;

3.15.3 Northern Ireland Police Misconduct – death in police custody cell;

3.15.4 Crown Office & Procurator Fiscal Service – Prison restraint death, Scotland;

3.15.5 Corner case – Police restraint death, Derbyshire;

3.15.6 Coroner case – SIA hospital restraint death, London; and

3.15.7 Coroner case – SIA hospital restraint death, Lancashire.

3.16 I attended the National Police Trainers (England & Wales) course from 19th May to 3rd August 1994, and returned from the course to work at Cumbria police training unit. In October 1994 I was awarded a City and Guilds Further and Adult Education Teachers Certificate. In October 1999 I received my D32/33 Assessor award through South Cheshire College, and National Police Training. The D32/33 assessor award is a formal assessor qualification awarded through the Qualifications and Curriculum Authority, which was replaced by what was known as the 'A1 assessor award'. This award qualified a person to formally assess competency in the workplace against an established criteria. In 2001 I attended the National Police Training OSPRE assessor course for assessing Constable to Sergeant promotion procedures. OSPRE was part of the National Police Promotion Framework to assess a Constable in simulated situations for promotion to Sergeant. OSPRE was the acronym for 'Objective Structured Performance Related Examination'. In 2011 I was awarded the Ofqual level 4 'Preparing to Teach In The Lifelong Learning Sector' (PTLLS). Ofqual is a non-ministerial government department 'Office of Qualifications and Examinations Regulation', who regulate qualifications, examinations and assessment.

3.17 In March 1996, I attended a Home Office 6 weeks 'Train the Trainer' police trainers' programme. This was a course for delivering Community & Race Relations training throughout the Home Office forces.

3.18 In 2007 I was awarded the Institution of Occupational Safety & Health (IOSH) Managing Safely for Police Services award.

3.19 I hold BTEC awards for:

3.19.1 Self-Defence Instruction. Advanced Award 2012;

3.19.2 Safe and Effective Use of the Emergency Response Belt. Advanced Award 2014;

3.19.3 Safe and Effective Use of Restraint Equipment. Advanced Award 2014;

3.19.4 Conflict Management Training 2012; and

3.19.5 Physical Restraint Instruction. Advanced Award 2012.

3.20 I do have experience of attending knife incidents including a murder, which originated as a 'disturbance' call. Upon our arrival we found the suspect positioned over the victim, who was suffering from an arterial neck bleed. I was the duty Sergeant in company with a young officer, a probationer. I confronted the suspect with my baton drawn, keeping distance. The two of us arrested the suspect. Other incidents with pre-warned weapons have been attended following initial RV point attendance. Many incidents have involved weapons or threat of weapons only after initial attendance.

3.21 I have experience of drawing my baton at incidents and of striking a person with it. On one occasion I was the patrol Sergeant in company with a taller male Constable. The small young suspect, intoxicated with a substance, easily picked up and propelled away the male officer who was with me and turned to attack me. It was the fourth baton strike before he was temporarily incapacitated enough for us to control him, with the assistance of additional resources arriving.

3.22 I have experience working as a Sergeant in Cumbria Constabulary Civil Contingencies & Emergency Planning Unit (2008 to 2013) which involved representing Cumbria Constabulary on Local Resilience Forums, Regional Resilience Forums and National groups. This also involved cross border resilience forums with Police in Scotland. My role involved training police officers up to, and including, Chief Constable concerning major incident and critical incident management. I also trained staff from the multi-agency partnership concerning command and control. In 2011 I was a 'runner up' at the National Business Continuity Awards for innovative training design & delivery for major incident management in policing.

3.23 My role within the Civil Contingencies & Emergency Planning Unit was to increase the force preparedness for incident management. This involved my designing of exercises and training staff, the managing of the Gold command room during real incidents and debriefing real incidents to establish lessons to be learnt. It included designing plans for allowing the constabulary to have a command structure to deal with the major/unusual/critical incident whilst maintaining a command function to continue dealing with daily business.

3.24 Examples of real incidents which I was involved with concerning the Command and Control function, and subsequent debriefs include:

3.24.1 2008 - Original Mountain Marathon (OMM) fell challenge which involved over 2000 participants being on the Lake District fells during extreme weather. This resulted in a major incident being declared and a large-scale search and rescue operation, with Casualty Bureau and Reception Centres being activated.

3.24.2 2009 - Severe weather at Cumbria which caused bridges to collapse and a police officer to be killed. Critical infrastructure was destroyed.

3.24.3 2010 - A66 coach collision, involving the overturning of a school bus killing 2 children and seriously injuring others. Multiple casualties were evacuated from the scene to multiple hospitals around the North of England. Parents were arriving at the incident site looking for their children, and reporting their children as missing.

3.24.4 2010 - The Cumbria shootings by Derrick Bird who shot and killed 12 people and injured 11 others, in and around the Whitehaven area. Gold and Silver Command were at Police HQ, approximately 45 miles away.

3.25 In addition to real incidents, I designed and facilitated exercises involving a range of themes such as:

3.25.1 Nuclear release from Sellafield;

3.25.2 Chemical Biological Radioactive Nuclear (CBRN) transport incidents;

3.25.3 Mass evacuations;

3.25.4 Multiple arrests;

3.25.5 Custody unit closures; and

3.25.6 Force control room loss of power.

4 Report Introduction

4.1 The UK complies with the European standards for safer custody which includes all use of force on persons who are deprived of their liberty. This includes use of force by police, prison or mental health facilities. All use of force must be necessary, reasonable and proportionate at the time of its use, taking into consideration dynamic risk assessments and safety factors. Scotland is part of the UK group known as the National Preventive Mechanism (NPM) for sharing of information between all secure sectors for the safety of those detained, from the point of initial encounter. Use of force should not be viewed in isolation as a technique, but as an option taking into consideration other safer custody factors and control measures. NPM will be explained within Appendix F and later sections of the report.

4.2 A rank structure exists with the UK police service, with additional responsibilities and roles for a police response to emergency, critical or unusual incidents. The UK police service use the National Decision-Making Model (NDM) for the focus of risk assessment and decision-making. Officers are trained and provided with the relevant guidance documents/Authorised Professional Practices (APPs) in order to perform their allocated function during spontaneous, and often complex incidents. Preservation of life is a core priority for all incident management decisions.

4.3 'Custody' includes from the point of initial contact, arrest, transportation and the actual custody unit. The Police Scotland SOP 'Care and Welfare of Persons in Police Custody'[10] is the guidance document for all Police Scotland officers to follow. It includes the following explanations:

4.3.1 Section 3.1- Confirms that a person is in custody from the point of initial arrest;

[10] PS11014

4.3.2 Section 6.3 - Any apprehension should be with the minimum amount of force necessary;

4.3.3 Section 9.8.1- Custody includes the initial contact, which may be some time before they are arrested; and

4.3.4 Section 10.2 – Any requirement for immediate medical attention from the place of arrest takes priority over apprehension.

4.4 Within my report I will consider all police involvement from the receipt of the initial call by the Area Control Room (ACR). This is because the use of force should not be viewed as an isolated topic. All staff involved from the initial call received influence the police response by the information they gather and the risk assessment they make upon that information. This influences how they 'grade' the incident through use of the NDM, how they dispatch officers to the incident, how those officers may respond at the incident, and whether those officers actually attend the incident.

4.5 Based upon the current information provided to me, I have considered and answered a range of questions asked and at the conclusion of my report I add an overall summary opinion.

5. The National Decision-Making Model

5.1 The National Decision-Making Model is commonly known as the NDM. Full details are at Appendix B, as per the College of Policing NDM[11]. The NDM is used throughout the College of Policing Authorised Professional Practice guidance documents and is adopted within the UK police and prison sectors. Police Scotland have adopted this model, and it is included in their Operational Safety Manual (OST Manual) and their policing guidance documents (SOPs). The model is more commonly referred to as the 'National Decision Model'. Call handlers within Area Control Rooms (ACRs) are also trained to use the NDM.

5.2 The NDM outlines a process for decision making. The first stage is to gather information and intelligence. This means taking into consideration information and intelligence provided. On the basis of the gathered information and intelligence, an officer will be able to make an assessment of the threat and risk faced, and develop a working strategy. This process is influenced by personal factors, such as experience and knowledge. People may use the NDM and still conclude different risks.

5.3 An accurate threat and risk assessment is the cornerstone of safety. If the information provided is inaccurate or misleading, this can result in an inadequate risk assessment with insufficient control strategies being deployed. Area Control Room supervisors and staff are taught the NDM, as are all officers from Constable to Chief Constable. Based upon the Area Control Room staff's initial assessment and grading of an incident they will initiate the initial deployment plan, and control measures.

5.4 The model requires officers to consider powers and policy, identify options and contingencies, take action and review what happened.

[11] https://www.college.police.uk/app/national-decision-model

5.5 The model requires officers to consider: What am I trying to achieve? Will my action resolve the situation?

6 RV Points and Command & Control

6.1 Rendezvous Point (RV) is a commonly used term throughout the policing and military sectors. I have been familiar with the term throughout my policing career, since February 1990. The term is still used as of 2022.

6.2 RV terminology is also commonly used throughout the category 1 (emergency) responders with regards to emergency planning and civil contingencies responsibilities for joint emergency services working. The police service is known as a category 1 responder, along with the ambulance service and fire service.

6.3 The term 'command and control' is used throughout the emergency services within the UK. A principle practice of three tiers – Gold, Silver and Bronze command is established for the levels of command for an incident deemed to be a high risk, complex, or critical incident. Bronze represents the scene management for operational delivery. Silver represents tactical management which is usually a locally managed command post. Gold is senior officer strategic command. One of my policing roles involved emergency planning and the creation of plans for major incidents. I have performed as an emergency planning advisor at several Gold command activations for major incidents.

6.4 A Police Support Unit (PSU) commonly works under the direction of the Bronze command. PSUs are trained to national mutual aid standards. I was a trained PSU Sergeant for use at pre-planned events and protests, but also covered as a PSU Sergeant for general duty, spontaneous incident, and deployment when the existing PSU Sergeant was away from their role. When on duty we would be deployed to incidents suspected to contain violence and/or weapons as we would be deployed with shields and full PSU equipment. PSU staff are trained to deal with angry and violent people who may have knives. Cumbria PSUs were deployed to London during the national riots, and I worked on the regional planning team for the deployment.

6.5 The Police Scotland 'Contact, Command & Control (C3) Division National Guidance'[12] includes the phrase RV points concerning a firearms incident or a high threat incident. Page 15 states: "Identify a Rendezvous point (RVP)". The term 'command and control' is a commonly used phrase throughout the UK police services. C3 was introduced to Police Scotland replacing 'Command and Control' (C2). At this point I do not have disclosed to me the Police Scotland 'Command and Control' national guidance relating to 2015. I believe that C3 was introduced to Police Scotland from 2016.

6.6 'Command and Control' is explained later in this report, but is comparable throughout the UK police service for basic management principles for incidents. It provides a flexible management structure for primacy and ownership of roles and responsibilities. The 2009 'Guidance on Command and Control' issued by the National Police Improvement Agency'[13] established the common principles for the police service to work to. Police officers from Constable to Chief Constable, and civilian equivalents receive a level of training commensurate to their rank and their role within the organisation. A control room Constable would likely receive more training than a patrol Constable, but significantly less than a control room Inspector would receive.

6.7 'Command and Control' can be defined as being the authority and capability of a police force to direct the actions of its own personnel and use of its equipment and assets. A constabulary will have a 'command and control' capability 24 hours a day to be actioned by those ranks and roles who are specified as being 'commanders' within command and control. The control room Inspector, commonly referred to as the Force Incident Manager (FIM) is trained to be an Initial Tactical Firearms Commander (ITFC) and authorised to take the position of Silver Commander in a spontaneous incident in order to manage the initial risk and deployment tactical plan.

---

[12] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.scotland.police.uk%2Fspa-media%2Fgwep0iv0%2Fcontact-command-control-c3-division-national-guidance.doc&wdOrigin=BROWSELINK

[13] https://library.college.police.uk/docs/acpo/Command-and-Control-2009.pdf

6.8 A principle of command and control is to ensure ACR staff are in a position to focus on and effectively manage the command and control of ongoing and dynamic incidents.

6.9 Within the command and control hierarchy, the control room Constables and civilian equivalent staff are known as 'controllers'. The Sergeants and civilian equivalents are known as 'controller supervisors' and the Inspector is known as the 'Commander'. A Constable within the control room cannot officially be a 'Commander' within 'Control and Command' of an incident.

6.10 Controllers manage the day-to-day business of risk assessing incidents and deploying standard resources. Particular incidents mandate the control room Inspector/Force Incident Manager to 'command' the incident. Such examples include:

6.10.1 Firearms incidents as the Initial Tactical Firearms Commander (ITFC)[14].

6.10.2 Police vehicle pursuits as the strategic commander[15].

6.11 UK police all adopt a comparable 'Command and Control' structure which feeds into the UK Government at COBRA (Cabinet Office Briefing Room A). This allows all of the UK to provide mutual aid in the event of major national incidents.

[14] PS10985, Armed Policing SOP 2014

[15] https://www.whatdotheyknow.com/request/247759/response/615835/attach/7/Redacted%20Vehicle%20Pursuits%20PSoS%20SOP%20Version%202%2000.pdf

7 Positional Asphyxia

7.1 Positional asphyxia is further discussed within my report. This topic has been taught to officers since the 1990s, and is discussed in detail within 'safer custody' and the use of force.

7.2 The Police Scotland Officer Safety Manual which was applicable in 2015 states at Module 1, section 11:

> **7.2.1** "POSITIONAL ASPHYXIA. (RESTRAINT RELATED ASPHYXIA). Positional Asphyxia (Restraint Related Asphyxia) can occur when a subject is placed in a position which interferes with the ability to breathe. Death can occur rapidly, and it may be the case that a police officer can be found to be liable. The risk factors which contribute to the condition are:
> • Subject's body position results in partial or complete airway constriction
> • Alcohol or drug intoxication (the major risk factors)
> • Inability to escape position
> • The subject is prone
> • Obesity
> • Age
> • Stress
> • Respiratory muscle fatigue, related to prior violent muscular activity (such as fighting with police officers)."
>
> **7.2.2** "SIGNS AND SYMPTOMS. Officers should recognise the following symptoms and be prepared to administer emergency first aid:
> • Body position restricted to prone, face-down
> • Cyanosis (bluish discolouration of the extremities)
> • Gurgling / gasping sounds
> • An active subject suddenly changes to passive or loud and violent to quiet and tranquil
> • Panic

• Verbalising that they cannot breathe.

When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the physiological response to that is accelerated breathing. When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface. If the subject's hands are restrained to the rear breathing ability may be restricted. This must be considered by the officer. The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia. Officers are encouraged to remove the subject from the prone position as soon as possible following restraint. The subject can then breathe without restriction and the officer can still carry out search procedures before executing the safe get-up technique."

7.3 The Police Scotland OST powerpoints which were used in 2015 state:

7.3.1 Positional Asphyxia is likely to occur when a subject is in a position that interferes with inhalation and/or exhalation and cannot escape that position

7.3.2 Death can occur rapidly

7.3.3 Restraints can increase the risk

7.4 Risk Factors which contributable to the condition:

7.4.1 Body position which restricts/blocks airway;

7.4.2 Alcohol/drug intoxication;

7.4.3 Inability to escape position;

7.4.4 Subject is prone/pinned against a surface/slumped forward;

7.4.5 Obesity;

7.4.6 Restraint;

7.4.7 Stress; and

7.4.8 Respiratory muscle fatigue.

7.5 The Fife Constabulary Use of Force General Policing SOP 2008 disclosed to me covers positional asphyxia at section 5.13.

7.6 The Police Scotland Use of Force SOP 2013 disclosed to me covers positional asphyxia at section 21.2.

8 Excited Delirium / Acute Behavioural Disturbance

8.1 UK police officers have been taught common information concerning excited delirium and acute behavioural disturbance. This will be discussed in additional detail within my report.

8.2 The Police Scotland OST Manual covers this topic at Module 1, section 12, and states:

> **8.2.1** "EXCITED DELIRIUM. WHAT IS EXCITED DELIRIUM? This is when a subject exhibits violent behaviour in a bizarre and manic way. Excited delirium is a rare form of severe mania which may form part of the spectrum of manic-depressive psychosis and chronic schizophrenia. It is characterised by constant, purposeless, often violent activity with incoherent or meaningless speech and hallucinations with paranoid delusions. Subjects can be dangerous and may die of acute exhaustive mania. Hyperthermia (overheating and profuse sweating, even in cold weather) is often part of this condition. WHY IS A SUBJECT IN AN EXCITED DELIRIUM STATE OF PARTICULAR CONCERN? Subjects suffering from excited delirium can die suddenly during, or shortly after, a violent struggle. This could occur whilst at hospital or in custody. HOW IS IT CAUSED? A combination of either drug intoxication, alcohol intoxication or psychiatric illness. Cocaine is the most commonly associated drug with this condition, however other drugs have the potential to induce excited delirium."
>
> **8.2.2** "HOW DO OFFICERS IDENTIFY A SUBJECT IN A STATE OF EXCITED DELIRIUM?
> • They will be abnormally strong
> • They will be abnormally tolerant to pain
> • Incapacitant sprays may not work on them
> • Their skin may be hot
> • They may be hallucinating, hiding behind objects, running around or pulling their clothes off
> • They may suddenly become subdued or collapse after a bout of extreme violence

ACTIONS TO REDUCE RISK OF DEATH IN RESTRAINED SUBJECT EXHIBITING EXCITED DELIRIUM

• The subject should be placed onto their side, or into a kneeling/seated position as soon as possible

• A subject who has been restrained and exhibits symptoms of excited delirium should be visually and verbally monitored closely

• The subject should not be transported in the prone position, if at all possible

• Officers should be prepared to administer first aid if the subject's condition deteriorates.

Any subject exhibiting symptoms of excited delirium should be treated as a MEDICAL EMERGENCY and be assessed immediately at a hospital."

8.3 The Police Scotland OST slides used in 2015 cover the topic and include:

1. "A person exhibits violent behaviour in a bizarre and manic way
2. Constant, purposeless, often violent activity
3. Meaningless speech and hallucinations with paranoid delusions
4. Abnormally strength and pain tolerance
5. CS may not work

Causes

1. Drug and/or alcohol intoxication
2. Psychiatric illness
3. Or a combination of the above

Medical Emergency

1. Expect a sudden collapse
2. Acute exhaustive mania can be fatal"

8.4 The Fife Use of Force SOP 2008 covers the topic at section 21.3.

8.5 The Police Scotland Use of Force SOP 2013 covers the topic at section 21.3

9 Question 1 - Management of the Incident: Command and Control

Please note that a critical incident was declared by Chief Superintendent Gary McEwan at approximately 09:10, upon learning of Sheku Bayoh's death.

- **9.2 Question 1.1 In light of the information known to the ACR (terror threat level; date and time of call; 999 and 101 calls), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public?**
- **9.3 Question 1.2 Would you expect an ACR in Edinburgh to be able to access local information about a locus in Kirkcaldy (in particular, whether the area was residential or commercial; proximity to hospitals, churches etc)? If so, how would this information be accessed? When would you expect these enquiries to be made?**
- **9.4 Question 1.3 If not, would you expect a reasonable ACR Inspector to make; be making or have made, appropriate enquiries from the response team or others as to the nature of the locus? When would you expect these enquiries to be made?**
- **9.5 Question 1.4 What conclusion would a reasonable ACR Inspector have reached as to the likely risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public; and why?**
- **9.6 Question 1.5 How would that assessment inform a reasonable ACR Inspector's decision making in terms of (i) the categorisation of the incident, (ii) the resources to be allocated to the incident, and (iii) the ongoing management of the incident?**
- **9.7 Question 1.6 How would a reasonable ACR Inspector have categorised the incident (in particular: Grade? Firearms? Critical?); and why? When would a reasonable Inspector have taken this decision vis-à-vis the arrival of the response team?**
- **9.8 Question 1.7 What resources would a reasonable ACR Inspector have deployed to the incident and why?**

- **9.9 Question 1.8 In your opinion, would a reasonable ACR Inspector require feedback from response officers dispatched to the locus in order to complete his assessment as to the appropriate categorisation of the incident, and the resources and management it required? How long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? How long would a reasonable ACR Inspector take to implement any such steps?**
- **9.10 Question 1.9 If response officers were already en route to the locus by the time a reasonable ACR Inspector learned of the incident, how long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? In the absence of any feedback, how long would a reasonable ACR Inspector take to implement any such steps?**
- **9.11 Question 1.10 What directions, if any, would he have given to those officers and when?**
- **9.12 Question 1.11 (Depending on your view as to how a reasonable ACR Inspector would have categorised the incident as firearms, critical etc) What procedures and steps would then have been implemented to manage the incident?**
- **9.13 Question 1.12 Please describe the roles and responsibilities of the various personnel who would have been involved in the command and control of the incident, with particular reference to (i) the ACR; (ii) senior officers within Fife Police and Kirkcaldy Police Office; and (iii) individual response officers.**
- **9.14 Question 1.13 In your opinion, had the incident been declared a firearms incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a firearms incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).**

  9.15 Question 1.14 In your opinion, had the incident been declared a critical incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a critical incident

had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).

Caveat: The opinions expressed in the following chapters are based on the evidence and information available to me as at the date of this report. Should further relevant evidence or information become available, I may require to reconsider my opinions.

9.1 General Explanation. Expert Witness considerations of law, policy and procedures concerning 'Command and Control'.

9.1.1 Until any additional disclosure of relevant information, the law and guidance which was available and relevant for me to consider, for the initial command and control of this incident, includes:

9.1.1.1 The 2011 Association of Chief Police Officers Scotland (ACPOS), Association of Chief Police Officers England & Wales (ACPO), and National Police Improvement Agency (NPIA) Manual of Guidance on 'The Management, Command and Deployment of Armed Officers.[16]

9.1.1.2 Police Scotland Armed Policing Operations SOP 2014;[17]

9.1.1.3 The Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005. The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Amendment Regulations 2013 (the Regulations);

9.1.1.4 ACPO 2008 Taser policy;[18]

9.1.1.5 2007 NPIA Practice Advice on Critical Incident Management;[19]

---

16 https://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations%20FOI/2012/093%2012%20%20Att%2001%20of%201%20Management%20Command%20and%20deployment%20of%20Firearms%20Officers.pdf

17 PS10985

18 https://statesassembly.gov.je/scrutinyreviewresearches/2012/research%20-%20%20operational%20use%20of%20taser%20policy%20and%20guidance%20-%20police%20use%20of%20tasers%20in%20jersey%20-%2012%20december%202008.pdf

19 https://www.npcc.police.uk/documents/crime/2007/200708-cba-critical-incident-management.pdf

9.1.1.6 Police Scotland Critical Incident Management SOP 2014; [20]

9.1.1.7 Call handling and incident grading standards;[21] and

9.1.1.8 Force Incident Manager (FIM) role profiles.[22] (English role profiles have currently been reviewed subject to Police Scotland disclosure of the ACR Inspector role profile.)

9.1.2 The 2011 ACPOS/ACPO Manual of Guidance on 'The Management, Command and Deployment of Armed Officers' was applicable throughout the UK for a comparable police response to incidents. This was replaced in 2013 by the online Authorised Professional Practice 'Armed Policing' APP[23] which is updated online. Both copies are still comparable online. Police Scotland Armed Policing Operations SOP 2014, which was valid at the time of the incident, states that the College of Policing APP is adopted by Police Scotland. This means England, Scotland and Wales are working to the same guidance.

How a police control room operates. **Common practices throughout the UK**.

9.1.3 The most senior officer on duty in the control room is the Inspector. The Inspector is commonly called a Force Incident Manager (FIM). Common practice throughout the UK is that acting Inspectors are not permitted to perform this function. The Inspector/FIM receives additional training to that of a general patrol Inspector, particularly focusing upon incident management, command and control.

9.1.4 The Inspector is responsible for the initial assessment, strategic intervention and management of spontaneous incidents, providing a 24/7 single point of contact for the constabulary in regards to risk and threat management. Controllers within the control room act on the Inspector's behalf. The controller uses the National Decision-Making

---

[20] PS11003

[21] https://library.college.police.uk/docs/homeoffice/call_handling_standards.pdf

[22] https://www.bing.com/search?q=Cheshire+force+incident+manager+role+profile&qs=n&form=QBRE&sp=-1&ghc=1&pq=cheshire+force+incident+manager+role+profile&sc=4-44&sk=&cvid=E865FE5604F9472CBD16607B3F52FD83&ghsh=0&ghacc=0&ghpl=

[23] https://www.college.police.uk/app/armed-policing

Model (NDM), considering threat, harm, risk, investigation requirements, vulnerability issues and basic engagement plans. They dispatch officers and monitor progress. They must alert supervisors and/or the control room Inspector as required for incidents which require a command decision, as they are not commanders. I am currently awaiting disclosure of Police Scotland control room staff role profiles.

9.1.5 Inspectors/FIMs plan, manage and monitor operational policing activity. They effectively and efficiently direct the deployment of resources to incidents, including critical incidents. Inspectors manage and mitigate risk effectively in order to ensure the safety and wellbeing of officers, staff and the public, and to respond effectively to problems, incidents and crime.

9.1.6 Inspectors/FIMs are responsible for managing competing demands and priorities to make informed deployment decisions and ensure best use of available resources. Routine incident management can be dealt with by the controllers.

9.1.7 Inspectors/FIMs manage the initial response to critical incidents, in alignment with relevant frameworks and guidance, ensuring appropriate resource allocation and risk management.

9.1.8 Inspectors/FIMs identify, manage and mitigate operational threats and risks in line with national guidance and operational policing plans in order to ensure the safety of officers, staff, and the public.

9.1.9 Inspectors/FIMs maintain a live-time strategic perspective on force wide policing demands and response to incidents, ensuring regular liaison with area supervision and senior managers, and escalation of deployments as appropriate.

9.1.10 Inspectors/FIMs assess incidents which may require the spontaneous deployment of Authorised Firearms Officers in line with the NDM and relevant guidance on the management, command and deployment of armed officers, and to manage the initial phase of such deployments, acting as Initial Tactical Firearms Commander.

9.1.11 Inspectors/FIMs identify and initiate appropriate and timely action in response to major incidents or critical incidents, acting as 'Silver Commander' to ensure that public safety and public reassurance issues are addressed.

9.1.12 Inspectors/FIMs identify, assess and initiate incidents involving high risk "crime in action" calling upon the appropriate specialist resources to manage their investigation.

9.1.13 Inspectors/FIMs lead a team of staff to ensure that call handling performance, and appropriate resource deployment is maximised with particular regard to the safeguarding of vulnerable persons and quality service delivery.

9.1.14 The Inspector/FIM will have deputy officers within their team who can temporarily take control in the Inspector's absence, but they are not the FIM or Initial Firearms Tactical Commander (IFTC).

9.1.15 When a call is received by a call hander, within the control room function a process commences. The call handler assesses whether a police response is required and the priority of that response by conducting an assessment. Two assessment models are commonly used:

9.1.15.1 The National Decision-Making Model (NDM); and

9.1.15.2 The THRIVE assessment (a risk management tool). (I am unsure when Police Scotland began using this tool, or which alternative they were using in 2015.) THRIVE stands for Threat, Harm, Risk, Investigation, Vulnerability and Engagement.

9.1.16 To gather and accurately assess relevant information to enable them to apply the THRIVE assessment, call handlers use the National Decision-Making Model. The NDM model has five stages which are:

9.1.16.1 Gather Information and Intelligence;

9.1.16.2 Assess situation;

9.1.16.3 Consider Powers & Policy;

9.1.16.4 Identify Options; and

9.1.16.5 Take Action and Review.

THRIVE is a risk management tool which considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident.

9.1.17 Threat includes identification of whom or what is subject to any threat and what threat has been made. Consideration should be given to whether there is a threat targeted towards a person, property, service reputation, public safety, or a community;

Harm includes considering potential harm. The assessment should be made that if any threat identified were realised or the circumstances of the incident were to deteriorate, what would the harm caused be? For example, serious injury to a person or a substantial amount of damage to property.

Risk includes the possibility of something occurring. This should be considered when determining the response grade. The imminent threat of violence to persons or damage to property, serious offences in progress, the presence of suspects at scenes or potential evidence loss, would dictate a more urgent response. For example, a threat of violence made in person to the intended victim.

Investigation will consider if there is a need for an investigation. If so, in what form? Consideration should be given in determining the nature of the response to an incident in terms of its investigative requirements to areas such as a serious crime in progress for forensic evidence.

Vulnerability will include consideration for a person being vulnerable if as a result of their situation or circumstances, they are unable to take care or protect themselves or others, from harm or exploitation. This would include mental illness or physical illness.

Engagement will question if police need to engage and if so when and how?

9.1.18 The incident will then need to be graded for its response. Call handlers may seek guidance from the Inspector/FIM if they are unsure. As the incident progresses through

the Control Room process, the incident can be re-graded in light of new information. A grade 1 response means:

9.1.18.1 There may be an immediate threat to life;

9.1.18.2 A serious crime is in progress or likely to occur or a suspect for a serious crime is present or nearby;

9.1.18.3 To allow evidence of a serious crime to be secured, that would otherwise be lost;

9.1.18.4 A road traffic collision involving personal injury has occurred;

9.1.18.5 Where a person who is especially vulnerable needs urgent assistance; or

9.1.18.6 The person receiving the call assesses that an immediate response is required.

A grade 1 call will also be subject to target times. A target time does not mean that risk assessment is compromised, and if justified, a grade 1 call can be delayed.

9.1.19 It is the responsibility of the control room to manage the initial response to an incident, until such time that management of the incident is suitable to be transferred to another competent person, and function. The Inspector/FIM will determine the urgency of the response required based on all available information and determine what resources will be required to attend, to meet the current threat level. This will, where necessary, require units to be diverted at the discretion of the Inspector/FIM. The responsibility ultimately lies with the Inspector, but functions are delegated to controllers for routine incident deployment. Controllers would be expected to inform a supervisor or the Inspector if an incident is not usual, or triggers mandatory referral.

9.1.20 Primacy for the deployment of resources in relation to incident management rests with the Force Duty Silver Commander (FIM)/Control Room Inspector). Deployment will be managed in conjunction with local supervision, but in the event of a dispute over deployment to a particular incident the Force Duty Silver commander will direct attendance, as they have ‘primacy’.

9.1.21 Response to incidents requires a clear command and control structure determining who is responsible for the deployment of police resources. The Control Room Inspector will be in command until the incident is deemed suitable to be transferred to another person. That other person must be competent to command the level of incident, and know they are the commander of it. Controllers act on behalf of the Inspector and delegated authority is given for routine patrol staff to be deployed to routine incidents which do not pose high risk, unusual incidents, critical incidents, major incidents, and/or mandatory referrals such as firearms and police pursuits.

9.1.22 The deputy of the control room supervisor is commonly a civilian senior grade operator. Historically this role was a police Sergeant. At this time I do not have the role profiles for Police Scotland.

9.1.23 Both Police Scotland and England use the STORM command and control system. Police Scotland Control Room Inspectors are trained tactical firearms commanders who train to the same standards as the English Control Room Inspectors/FIMs. All of the UK feed into the UK command and control process for mutual aid. Comparable practices are essential for efficient mutual aid.

9.1.24 The Control Room Inspector, Inspector Steven Stewart, was trained for command and control for the deployment of armed responses. He stated in his evidence:

> **9.1.24.1** "So if an incident came into the control room in terms of a live incident, someone in possession of a handgun, someone in possession of a knife or an axe, I would make that determination based on my training as to whether or not it was a declared firearms incident and then I would deploy ARV resources to deal with that and brief them on the way and advise them of tactics and sort of control these specialist resources to the incident."[24]

[24] Line 17 page 145 Day 5 transcript

9.1.24.2 "Information from the scene is probably vital to come back to me as a commander in the control room"[25]

9.1.24.3 "the controller's got responsibility for looking at the resources, looking after them, so there's a mapping system, so they can see on the mapping system which resources would attend and so the controller would know who was free, who was involved with another incident, who they had to tell to breakaway to attend an incident."[26]

9.1.24.4 "the College of Policing definition about the criteria for the deployment of firearms officers to an incident talks about reason to suppose that persons are in possession of, or have immediate access to a firearm or other lethal weapon, so it could be a knife, it could be an axe, it could be a bow and arrow".[27]

9.1.24.5 "I asked Michelle Hutchinson to make contact with a dog unit and also to make the ARVs aware of an incident that was happening in Kirkcaldy".[28]

9.1.25 The Police Scotland Armed Policing SOP 2014 states that although 'contain and negotiate' is the preferred methodology for response to such incidents, there is no one single tactic which will meet the requirements of all incidents. This is why trained staff are required to advise and control incidents, for flexibility of approach based upon the NDM and individual circumstances. "The deployment of AFOs should only be authorised in the following circumstances" and includes "where the officer authorising the deployment has 'reason to suppose' that officers may have to protect themselves or others from a person who is in possession of, or has immediate access to, a firearm or other potentially lethal weapon or is otherwise so dangerous that the deployment of armed officers is considered to be appropriate." The Police Scotland Armed Policing SOP 2014 states at section 8.4 that "this may include situations where the suspect is not in possession of a firearm or other potentially lethal weapon". "Chief officers must ensure that there is an officer immediately available in their force area to consider and authorise the

[25] Line 5 page 166 Day 5 transcript
[26] Line 11 Page 173 Transcript Day 5
[27] Line 4 Page 211 Transcript Day 5
[28] Line 6 Page 216 Transcript Day 5

deployment of AFOs where one or more of the criteria for deployment have been met". This would include Inspector Steven Stewart, as the Control Room Inspector, to be able to authorise deployment of Armed Firearms Officers (AFOs). Controllers cannot authorise the deployment of armed officers, it requires a commander.

9.1.26 Police Scotland Armed Policing SOP section 9, refers to spontaneous incidents and what information must be passed to the ACR. At section 9.4, it states that the Initial Tactical Firearms Commander (ITFC) will be in command of the incident. Inspector Stewart confirms in his statement[29] that he was an ITFC.

9.1.27 The initial authority for the deployment of AFOs can be given by an accredited Strategic Firearms Commander (SFC) or a Tactical Firearms Commander (TFC). In spontaneous incidents, where the initial authority is given by a TFC, an SFC should be contacted as soon as practicable and informed that an incident requiring the deployment of armed officers is taking place. Where the SFC is in a position to take a command role, they will do so, and make command decisions. This confirms that Inspector Stewart could authorise and deploy an AFO/ARV response. Once deployed he must bring it to the attention of the on-duty Gold commander.

9.1.28 It is the responsibility of the officer deploying AFOs to ensure that an appropriate command structure is instigated as soon as is practicable. Police Scotland Armed Policing SOP 2014 states that "Any deployment of police resources to alleged high threat situations should follow safe response procedures unless there are sound and objective reasons to discount the allegations". At section 9.7 of the SOP it states: "These procedures will also apply where the incident does not involve a person in possession of a firearm but where they are considered otherwise so dangerous".

9.1.29 The generic command structure used in the UK police service operates at three levels – strategic/Gold, tactical/Silver and operational/Bronze. The command structure offers flexibility in response to a varied and developing range of circumstances and is

[29] SBPI-00084

functional rather than based on rank. The structure must be clearly articulated to all those involved. The common principle is that a Control Room Inspector/FIM assumes the role of Silver commander in the initial stages of all incidents. This would mean that Inspector Stewart is the Silver commander until it is concluded that no commander is required, or command is formally handed over to another competent person.

9.1.30 "On receipt of a suspected firearms incident the Controller will immediately alert the Initial Tactical Firearms Commander (ITFC) of the incident."[30]

9.1.31 "Any deployment of police resources to alleged high threat situations should follow safe response procedures unless there are sound and objective reasons to discount the allegations."[31]

9.1.32 Responsibility of the controller: "Any unarmed resources directed to attend the locus should be instructed to make/consider safe observations/enquiries in line with the College of Policing Stay Safe at Firearms Incidents only and not to approach or detain persons who may be armed." And "Consideration should be given to having an ambulance placed on standby at the RVP or other suitable area."[32]

9.1.33 "Unarmed observations or enquiries should be conducted by the safest possible means."[33]

9.1.34 "It is essential that ACR staff monitor incidents and ensure that clear instructions are broadcast that unarmed officers are to carry out safe observations or enquiries only and are not to approach or secure subjects who pose a potential firearms threat."[34]

---

[30] Section 9.4 Police Scotland Armed Policing SOP 2014
[31] Section 9.6 Police Scotland Armed Policing SOP 2014
[32] Section 9.8 Police Scotland Armed Policing SOP 2014
[33] Section 9.9.4 Police Scotland Armed Policing SOP 2014
[34] Section 9.9.7 Police Scotland Armed Policing SOP 2014

9.1.35 Where an incident is reported and operational deployment of AFOs is considered. the command structure is likely to be condensed. Initial command will usually sit with the control room tactical firearms commander.[35]

9.1.36 "In spontaneous incidents it is the responsibility of the officer authorising the deployment of AFOs to ensure that an appropriate command structure is instigated as soon as practicable. Where appropriate, this officer should remain in command of the deployment until any transfer of command takes place." [36]

9.1.37 "It is the duty of the police service to safeguard the public, however police officers must not be expected to endanger their own lives or the lives of their colleagues in ill-considered attempts at rescue or to effect an early arrest."[37]

9.1.38 In the spontaneous context it will often be the initial TFC that approves the tactical plan or response and authorises the deployment of armed officers.

9.1.39 Initial command will usually sit with the appropriately accredited person having ready access to information, communications and resources (this may be the force control room supervisor). Forces should, therefore, have structures in place that ensure the ready availability of tactical and operational firearms commanders.

9.1.40 It is important for effective command to be established as quickly as possible and undertaken by the most appropriate person available. The 'most appropriate person' factors include:

9.1.40.1 Knowledge of the circumstances and available intelligence;

9.1.40.2 The ability to communicate;

9.1.40.3 The availability of appropriate tactical advice; and

9.1.40.4 A suitable environment from which to exercise the command function.

---

[35] Section 5.30 2011 ACPO ACPOS NPIA Manual of Guidance on the Management Command and Deployment of Armed Officers
[36] Section 5.28 2011 ACPO ACPOS NPIA Manual of Guidance and
[37] Section 8.3.1 Police Scotland Armed Policing Operations SOP 2014

9.1.41 The 'appropriate factors' sit comfortably with the Control Room Inspector role.

9.1.42 In all cases where AFOs have been deployed, commanders must regularly review the need for their continued deployment.

9.1.43 The Tactical/Silver Firearms Commander is advised to perform certain functions which include:

9.1.43.1 Must assess and develop the available information and intelligence, and develop an appropriate threat assessment and working strategy;

9.1.43.2 Is responsible for developing and co-ordinating the tactical plan;

9.1.43.3 Should consider the provision of medical support;

9.1.43.4 Should be so located as to be able to maintain effective tactical command of the operation;

9.1.43.5 Should ensure that all decisions are recorded, where practicable, in order to provide a clear audit trail;

9.1.43.6 Should ensure that an operational risk assessment is undertaken prior to deployment;

9.1.43.7 Should consider declaring and managing the event as a critical incident; and

9.1.43.8 Should consider the wider community, public safety and evidential implications.

9.1.44 Initial command will usually sit with the appropriately accredited person having ready access to information, communications and resources (this may be the force control room supervisor). Inspector Stewart was an accredited person on duty to manage any firearms incident. Possession of a firearm is not essential to respond under the principles and practices of a firearms incident. Staff did request firearms attendance and controllers did make enquiries to establish the availability for an ARV to attend.

9.1.45 Commanders must, at the earliest opportunity, develop an effective working strategy to direct police action. A working strategy may start to be developed once

information is received. It can be formalised once a threat assessment has taken place, but should be kept under review as circumstances evolve. A working strategy may contain a number of objectives. Information and intelligence can change, as can the threat assessment. Therefore, the working strategy must remain dynamic, kept under review and amended as appropriate.

9.1.46 "Public safety should always be the priority and at times this may require immediate action to protect life, which, of necessity, may be based on limited information"[38]

9.1.47 "Along with the primary aim of securing public safety, consideration should be given to whether it is possible to identify, locate and contain the subject and take appropriate action to neutralize the threat posed."[39]

9.1.48 "Generic tactical options to consider include:

- Waiting;
- Taking mitigating action;
- Keeping the subject under observation;
- Carrying out an investigative assessment;
- Containing the area around the subject, thereby minimising the opportunity for harm;
- Communicating with the subject;
- Taking decisive action."[40]

9.1.49 Section 5.2 of the 2011 ACPOS/ACPO 'Manual of Guidance on The Management, Command and Deployment of Armed Officers' states: "when an officer

[38] https://www.college.police.uk/app/armed-policing/command
[39] Section 6.33 ACPO ACPOS NPIA 2011 Manual
[40] ACPO ACPOS NPIA 2011 Manual

has attended and satisfactorily completed a course of instruction based on a command or tactical advice module in the National Police Firearms Training Curriculum, they will be assessed as being occupationally competent to perform that role." Officers in command and tactical advisor roles must be formally re-accredited at least every five years, but consideration should be given to re-accreditation between three to five years depending on operational exposure. Commanders are required to attend annual refresher training. The ACR Inspector had completed this course and attended refresher training.

9.1.50 Gold command is the strategic group of senior managers and support staff, who set the strategic objectives and any tactical parameters. Silver command develops, commands and co-ordinates the overall tactical response. Bronze command is the operational delivery of the police response. This command structure is a UK wide functional command structure for all incidents, and can be used for event planning and major incident and/or critical incident response.

9.1.51 Scotland, along with the remainder of the UK, use common definitions and objectives to define aspects of incidents. Although every emergency has unique characteristics which must be considered, the following is a generic guide relevant to all management levels:

9.1.51.1 Protecting human life, property and the environment;

9.1.51.2 Minimising the harmful effects of the emergency;

9.1.51.3 Managing and supporting an effective and coordinated joint response;

9.1.51.4 Maintaining normal services as far as is possible;

9.1.51.5 Supporting the local community and its part in recovery; and

9.1.51.6 Managing and supporting an effective and co-ordinated joint response.

These are principles which derive from the Civil Contingencies Act (Scotland) 2004 for emergency planning and response.

9.1.52 Within the category 1 responders (police, fire, ambulance), incidents broadly fall into two categories:

9.1.52.1 Spontaneous: those for which there is no or very little prior warning; and

9.1.52.2 Non-spontaneous: those where some early indication of a potential incident exists.

9.1.53 The Civil Contingencies Act (Scotland) 2004 defines the term 'emergency'. The definition includes: An event or situation which threatens serious damage to human welfare in a place in the United Kingdom, or terrorism. Threatens damage to human welfare includes (a) loss of human life or (b) human injury.
Incident recording and call handling guidelines also exist for control room staff to assist them to decide what grades and categories to allocate to incidents.

9.1.54 Police Scotland has authorised the use of Conducted Energy Devices (CED), also commonly referred to as Taser, for Specially Trained Officers (STOs) and will deploy in accordance with national policy agreed by the National Police Chiefs' Council (NPCC) and College of Policing (COP) Authorised Professional Practice. Tasers may be deployed and used as one of a number of operational safety tactical options only after application of the National Decision Model (NDM). The ACR supervisor must record an assessment of the level of risk and an NDM-based rationale for deployment (including the appropriate working strategy), and maintain an overview of the incident and escalate/de-escalate where appropriate. Generally, STOs are regular patrol officers accessible 24 hours a day through ACRs if required. The availability or deployment of STOs should not be considered a replacement for conventional firearms if the relevant criteria for the deployment of armed officers are met. I am informed at the time of this incident the STOs for use of Taser within Police Scotland were the ARV staff, and not patrol officers. As a force response, Police Scotland would be obligated to have available a firearms capability for deployment, if required. The Control Room Inspector/FIM can deploy these officers to an incident. Deployment of Taser can negate the need to physically restrain a person.

9.1.55 Critical Incident Management (CIM) has its origins in the response to the public Inquiry which followed the investigation into the murder of Stephen Lawrence in 1993. A critical incident is defined as any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their

family and/or the community. A critical incident was declared by Chief Superintendent Gary McEwan at approximately 09:10, upon learning of Mr Sheku Bayoh's death.

9.1.56 An incident which has the likelihood to be categorised as a critical incident should be addressed promptly and efficiently. Deaths in custody are considered to be critical incidents. All firearms officer deployments have the potential to be a critical incident, and if an incident is deployed as a firearms incident, one of the early considerations is to categorise the incident as a critical incident in addition to the firearms 'marker' being added to the STORM log.

9.1.57 The 2014 Police Scotland Armed Policing SOP outlines what should occur, in response to a high threat incident which may justify the deployment of AFOs. This includes:

9.1.57.1 The control room staff member notifies the Area Control Room duty officer i.e. Inspector Stewart. (The control room staff did not categorise the incident as a firearms incident but did locate ARVs and dog handlers. It was endorsed with 'knife'. This appears to indicate there are concerns with this incident beyond a standard incident, as ARVs and dog handlers are not routinely considered).

9.1.57.2 The area supervisors who were the patrol Inspector and Sergeant, were informed i.e. acting Inspector Stephen Kay and acting Sergeant Scott Maxwell. (acting Sergeant Maxwell requested that the ARV and dog handler attend the incident, indicating he believed it to be a high risk incident for ARV deployment. Area supervisors requesting ARVs and dog handlers to attend incidents is not routine incident management). According to Police Scotland procedures, the local supervisor is to become the Police Incident Officer – PIO.

9.1.57.3 Any unarmed officer attending should be informed to make/consider safe observations in line with the College of Policing 'stay safe at firearms incidents' message. This message is known as the 'Stay safe: Keeping the public

and unarmed responders safe at incidents involving the use, or suspected use, of potentially lethal weapons or firearms, active shooters and marauding terrorist attack'. Unarmed officers attending should not engage with the person. They should not approach or detain a person who may be armed. (The controller did not pass a stay safe message to the responding patrols).

9.1.57.4 Information/intelligence enquiries to be conducted. For example, contacting witnesses for additional information. (Witness was called back for additional information).

9.1.57.5 Consider specialist resources. (The ARVs and dog handlers were located and communicated with for attending this incident).

9.1.57.6 Establish nominated RV point. (No RV point was nominated).

9.1.57.7 Information must be communicated to the firearms commander(s) which may impact upon the safety of the public, police or subject.

9.1.57.8 The command and control system should include reference to the SID system (Scottish Intelligence Database).

9.1.57.9 Section 9.9.2 of the Police Scotland Armed Policing SOP poses the point that other enquiries can negate the need to immediately deploy unarmed officers, such as contacting the witness for more information.

9.1.57.10 Unarmed officers attending to conduct observations should be conducted by the safest possible means. Where applicable, the deployment of plain clothes officers instead of uniformed officers should be considered. (Plain clothes officers were not deployed prior to unarmed uniformed officers and officers were not deployed with specific instructions to conduct observations).

9.1.58 Section 9.9.6 of the 2014 Police Scotland Armed Policing SOP states that Police Scotland has “no acknowledged safe or effective method for unarmed officers to approach, control or secure a subject where there is reason to believe where there is reason to suppose that the subject may be in possession or have immediate access to” a weapon.

9.1.59 As per Police Scotland Command & Control guidance[41]: The ACR must notify Local Divisional Supervisors of all 'serious' and 'significant/major incidents'. These specifically include all firearms incidents, domestic incidents, vulnerable missing persons, hate crimes, sudden deaths, robberies, major incidents and serious road traffic collisions. This list is not exhaustive and ACR staff should consider individual circumstances when deciding to inform supervisors. All reported incidents involving a firearm, regardless of circumstances, must be firstly assessed by the Duty Officer in the respective Area Overview before any units are considered for deployment. In addition, any deployment of unarmed police officers to reported high threat situations should be advised to the Duty Officer of the relevant Overview. The Controller must notify the Divisional Sergeant and Inspector, as they will have responsibilities as the PIO. The Duty Officer and Overview team will undertake initial actions as per their training:

9.1.59.1 Develop the available intelligence picture, background checks on police systems and open source;

9.1.59.2 Ensure the 'Stay Safe' message has been broadcast on appropriate talk-groups;

9.1.59.3 Identify a Rendezvous point (RVP);

9.1.59.4 Additional resources considered and tasked/requested as appropriate;

9.1.59.5 Appoint an ACR Single Point of Contact (SPOC) who will ensure that a PIO has been identified and establish Estimated Time of Arrival (ETA) to RVP;

9.1.59.6 Ensure sufficient unarmed officers identified to RVP or as tasked by Overview.

9.1.60 Page 14 of the 2014 Police Scotland Armed Policing SOP states that the ACR ensures that clear instructions are broadcast that unarmed officers are to carry out safe observations only and are not to approach or secure subjects who pose a potential firearms threat. Responding officers should confirm that these instructions are being complied with.

---

[41] C3 Contact Command & Control SOP section 8. Awaiting Command & Control SOP for 2015

9.1.61 Considering specific questions asked, I note the timeline of incidents to the ACR as being:

9.1.61.1 1st call received at 07:10:14 to 07:12:16 from Harry Kolberg (as per caller transcription log). His report included “just as I passed him he thumped my car. It looked as if he was actually carrying a knife and he started chasing the car”. An incident log is created by the call handler (reference PS20150503-0743) timed at 07:14:16. This includes the wording “male with knife” and is graded by the operator as a priority 2 incident. Priority 2 would mean that a response is not required immediately. The log includes the description that the person is “big with muscles about 6ft”.

9.1.61.2 A 2nd call received at 07:10:16 from Simon Rowe who reported “I've just spotted a black man with what looked like a huge blade walking along Templehall Avenue towards the Hub garage”; “like a big kitchen knife”; “Just walking along the road with it”. This call may have been added to the log of 0743 above at 07:17:25. Staff member SCE039 endorses the incident log.

9.1.61.3 A 3rd call is received at 07:11:01 from Joyce Joyce and incident log number PS20150503-0745 is commenced timed at 07:15:42. Incident grade ‘AB-28 Disturbance’ is allocated with a marker “disorder” and “weapon involved” and graded a priority 1 incident. This reporter informs police “9 inch blade”. The incident log is endorsed by staff member SCE020.

9.1.61.4 A 4th call is received at 07:15:34 from Alan Pearson. He reported “there's a guy in the middle of the street with a knife in his hand” and “just along from the hospital”; “he's got a large knife, a large knife, 9 inch blade”.

9.1.61.5 At 07:15:50 Harry Kolberg made a second call to police. He reported “he's actually on the road between Hendry Road and the hospital in Kirkcaldy”; “He's jumping out trying to hit other cars, he's stopping vehicles. I dinae ken what's wrong wi him”.

9.1.61.6 The Inquiry timeline shows that it is 07:16:32 when PC Tomlinson is informed to divert and attend this incident. This is approximately 6 minutes from the first call having been initially received. Whilst this message is being passed

another call is being received and ‘Con 1’ who is PC Scott Masterton informs PC Tomlinson to ‘stand by’ whilst the additional call is being received.

9.1.61.7 At 07:16:36 the call is received from Linda Limbert who reports “he's carrying a huge big big knife”. Her call is added to log 0743.

9.1.61.8 When PC Tomlinson is initially engaged to attend by PC Masterton, the incident log shows no reference to the Control Room Inspector being involved in the decision-making process to deploy officers. This is an incident which could be considered a firearms incident by the ACR Inspector, which would then mandate how staff were deployed. Regardless of whether it was declared a firearms incident or not, an appropriate deployment plan must be considered. (see later for discussion)

9.1.61.9 The first endorsed management line is at 07:18:16 by ‘Overview E01’.

9.1.61.10 Inspector Stewart recorded in his PIRC statement[42] “My specific role as Duty Officer consist of having an overview of activity within the East Command Policing Area, with specific responsibility for control and co-ordination of specialist resources, which would include firearms, road policing, public order, negotiators, dog unit, air support, in fact, any specials, resources available to Police Scotland. This includes the appropriate deployment of these resources to support Divisional and local policing objectives.”[43]

9.1.61.11 Inspector Stewart recorded “That morning sometime after 0700 hours, I was occupied elsewhere in the building, but I don't recall for what purpose, I may have been talking to one of the control room Sergeants, but I cannot be sure. However, when I returned to the EOV (East Overview) I was made aware by the EOV Sergeant that there was an ongoing incident in the Kirkcaldy area regarding a male seen in possession of a knife. I immediately sat down at my desk and started to look the incident, to ascertain what exactly were the circumstances. My

[42] PIRC-00395
[43] Page 2 paragraph 2

immediate concerns were to ensure that the call had been actioned and that there were sets (resources) attending the call."[44]

9.1.61.12 Inspector Stewart recorded "At this time I considered that a Divisional response was appropriate."[45]

9.1.61.13 Inspector Stewart recorded "There were several calls coming in regarding the incident and I had tasked the RAID officer to establish if the calls were linked and at the same time had tasked the communications officer to establish the whereabouts of specialist resources, dispatch a dog unit immediately and make the firearms officers aware of a developing divisional incident on Kirkcaldy 1. At that point, I pressed the PTT (Press To talk) button on my console and I made a transmission to all officers attending the incident."[46] This would correspond with the timeline log as being 07:20:13 when the communication commenced. This concludes that by 07:20:13 Inspector Stewart was aware that several calls had been received, a knife was involved, and he had commenced looking at the incident. The first police vehicle stopped at the scene at 07:20:23, approximately 10 seconds after Inspector Stewart commenced talking on the airwave.

9.1.61.14 At this time I have not viewed a statement from Ms Michelle Hutchison concerning her incident risk assessment or deployment decisions.

9.2 Question 1.1 In light of the information known to the ACR (terror threat level; date and time of call; 999 and 101 calls), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public?

9.2.1 I am not aware of the location where Inspector Stewart was during the period of time he was away from his desk, or if he was in possession of an airwave terminal to hear

[44] Page 2 paragraph 7
[45] Page 3 paragraph 1
[46] Page 3 paragraphs 4-5

transmissions, or if any ACR staff had attempted to contact him by airwave or mobile phone. I am unaware of who is in command of the ACR function when Inspector Stewart is absent from the room. The command function of Initial Tactical Firearms Commander (ITFC) cannot be delegated to another person, and this function remains solely with the accredited ITFC, who must be available. The ACR function is not just about deploying officers to incidents. The ACR is responsible for the initial incident grading, based upon the initial threat and risk assessment. ACR staff are trained to use the NDM and national call handling grading. Relevant factors are commonly considered within three categories of person, object and place.

9.2.2 Control Room Inspectors/FIMs are required and expected to consider a range of factors for their role and responsibilities. In addition to standard resourcing and deployment they would need to consider a range of policies and procedures such as critical incident management and specialist police resources. Specific risk factors for this incident would include:

9.2.2.1 Male. A behaviour conducted by a large male in his 20s may be considered a higher risk than an 80 year old female due to the perceived physical capabilities of the body;

9.2.2.2 Armed with a large knife. All weapons present a risk to attending officers regardless of the age of the person. A person may also have additional weapons concealed on their body;

9.2.2.3 Size. A large person may imply strength and may require additional staff to deal with them;

9.2.2.4 Opportunity and intent to cause harm. Reports that the person is chasing or attacking people/property will increase the risk consideration;

9.2.2.5 Drugs/alcohol. Any belief that a person may be intoxicated will increase the risk for all parties due to possible impact upon behaviour, communication skills and unpredictable behaviour;

9.2.2.6 Skill level of the people involved. If a person is showing signs of skill such as martial arts, or military style training, this will increase the risk factor;

9.2.2.7 Clothing may or may not have an impact on the risk decision. E.g. is it appropriate for the weather?;

9.2.2.8 Skill levels and the numbers of officers available to attend;

9.2.2.9 Proximity to other people or places. Particular consideration to vulnerable people or locations. For example, a primary school nearby when approaching school start or finish time; a hospital; a mental health unit. Vulnerable locations may attract the suspect, or the suspect may have a connection to them;

9.2.2.10 Danger to others. As above, particularly vulnerable people may become involved in the incident. Residential areas pose risk for the public who may happen to come upon the subject;

9.2.2.11 Escape routes available to the subject which will increase the risk of the person escaping;

9.2.2.12 Too few officers to enable a containment;

9.2.2.13 Weather conditions for location. For example, wet weather could make the ground unstable/slippery for all involved;

9.2.2.14 Environment hazards such as water, roads, railway lines and bridges. (If applicable); and

9.2.2.15 Any local risk factors triggered such as terrorism?

9.2.3 All of these example risk factors are applicable to the officers attending the incident. Additionally, the ACR would need to consider any potential unusual aspects such as critical incidents, major incidents and terrorism. The initial NDM risk assessment is to be performed by the ACR staff in their decision-making process as to what level of grading to allocate to the incident, and what initial response will be adopted. As numerous reports are being received concerning a man with a knife, chasing vehicles, the concept of a death must be considered along with initial deployment strategies. Officers have reported in their evidence that the subject of terrorism was a consideration, and I note that Police Scotland had issued briefings to staff concerning the raised terrorism threat. The threat

had risen from 'substantial' to 'severe', with an Assistant Chief Constable briefing video[47] being circulated from 19th February 2015. I am currently unaware if any emergency plan was created concerning 'lone wolf' terrorism incidents, as described by PC Walker and PC Paton. If such a plan existed it should be accessible within the ACR and staff should comply with it. I would expect a reasonable ACR Inspector to comply with the plan. Information currently available to me is that managers involved in this incident did not prioritise terrorism as the incident. Critical incidents could include incidents of terrorism, death in custody, firearms deployment and any incident involving multiple casualties. The ACR Inspector will be trained to immediately consider a wide range of principles and practices, and to act as a Commander. They will regularly be faced with spontaneous incidents involving high risk, which is why they are provided with enhanced training. Commonly an ACR Inspector is required to be an experienced Inspector prior to any deployment to the ACR function.

9.2.4 A Police Scotland position statement records:

> **9.2.4.1** "On receipt of one of the foregoing incidents, the Controller should immediately bring this to the attention of the Duty Officer (Initial Tactical Firearms Commander "ITFC") in the respective Overview, either by way of a BLADE/OVERVIEW tag, airwave, telephone or potentially all of the aforementioned."
>
> **9.2.4.2** "The decision to authorise and deploy an ARV was the responsibility of the duty officer as an ITFC. No divisional supervisor could authorise and deploy an ARV."
>
> **9.2.4.3** "A dog unit could be deployed by a controller or the Duty Officer (ITFC) in Overview, either at the request of officers in local policing or based on the controller or Duty Officer's assessment of the incident."
>
> **9.2.4.4** "Use of Force deployment of a dog unit could have included the following circumstances: pursuing and detaining a suspect who presented as a threat"

---

[47] PS-01319

9.2.4.5 "A PSU could have been deployed in the following situations:" and includes "in cases of violent deranged person"

9.2.4.6 "The decision to deploy a PSU would not have been for a controller. It would have been a collaborative decision taken by the ITFC in Overview and the Inspector on the ground" (This would be acting Inspector Kay and Inspector Stewart.)

9.2.4.7 "Where there was an obvious or developing threat or risk at Violent Deranged Person ('VDP') incidents and the immediate deployment of public order resources was required, the Duty Officer at Service Overview, Inspector or Police Incident Officer ('PIO') can authorise the deployment and seek retrospective authority thereafter" (This would be Inspector Stewart, acting Inspector Kay and acting Sergeant Maxwell)

9.2.4.8 "In an unplanned, spontaneous event the mobilisation of resources required by the command structure was the responsibility of the on Duty Inspector in charge of communications"

9.2.5 PC Scott Masterton provided statements PIRC-00331 and SBPI-00067. He made the following statements:

9.2.5.1 "The incident was opened at 07:15 by a call taker 71589 who noted additional details."

9.2.5.2 "Within the ACR the call takers are situated on the opposite side of the Control Room."

9.2.5.3 "The call was initially showing as a disturbance."

9.2.5.4 "The dog unit was SD10. Another dog unit SD18 was mobilized also."

9.2.5.5 "I did not have contact with Inspector Stewart during the course of the incident."

9.2.5.6 "2 dog units were originally actioned to the incident by E01 and E03."

9.2.5.7 "The supervisor should be straight on top of the fact there's a grade 1 call, the ACR Inspector …. Should be straight on top of that call as well."

9.2.5.8 Dog unit SD10 was allocated at 07:18:38 and dog unit at 07:21. (Note it was 7:20:23 when the first police vehicle arrived at scene, nearly three minutes since dog handler SD10 was allocated to attend.)

9.2.6 According to dog handler PC Gary Wood SD18 his statement[48], his estimated time of arrival at the scene was 10-15 minutes from dispatch. Having been dispatched at 07:21 he could, therefore, have been at the scene between 07:31 and 07:36 hours. I am not currently aware of where SD10 was travelling from for their ETA.

9.2.7 Inspector Stewart recorded in his PIRC statement[49]: “I can confirm that my transmission is not an instruction to the officers to 'stand off' but merely a reminder for them to make a professional risk assessment of the circumstances facing them and report back in line with training.”[50]

9.2.8 Having worked as an operation patrol Sergeant and a PSU Sergeant, I have been deployed to planned and spontaneous incidents involving various risks. Considering the threat that a large man, armed with a knife, chasing vehicles, could pose to unarmed officers - this poses a high risk of injury to them if they attempt to detain him. Upon receipt of initial calls there is no victim identified who is physically injured, and no person currently being attacked. The report may be concerning an imminent serious crime, but also may be behaviours of an extremely vulnerable person such as a mental health crisis. It may also be an incident of disorder or possession of a knife. A police response is required, but due to the risk to all parties involved, that response should be managed with control measures. Multiple reports from members of the public increase the likelihood that this is a genuine report of a man with a knife. Knife incidents often refer to a situation where there is a clear subject and victim, but in this instance this was being reported as a mobile subject with no intended target.

---

[48] SBPI-00108.
[49] PIRC-00395
[50] Page 4 paragraph 1

9.2.9 The whereabouts of the ACR Inspector is unknown for the first few minutes of the command and control, but he was on the radio prior to officer arrival. The local acting Inspector had not intervened in the control of the incident, and the acting Sergeant was requesting ARV and dogs. The ACR Inspector would have many factors to take into consideration for initial tactical decision-making. A plan had not been agreed or implemented. The ACR Inspector, as the Force Incident Manager and the on-duty Initial Tactical Firearms Commander could have immediately called “abort” or similar wording to divert unarmed staff away from the initial arrival. This would allow for the ACR Inspector to review the risk and threat assessment, and make a tactical decision concerning the deployment of specialists such as the dog handler(s). The dog handler, if his estimate is correct, was not an excessive time away from the scene.

9.3 Would you expect an ACR in Edinburgh to be able to access local information about a locus in Kirkcaldy (in particular, whether the area was residential or commercial; proximity to hospitals, churches etc)? If so, how would this information be accessed? When would you expect these enquiries to be made?

9.3.1 Yes. I believe that Kirkcaldy is within a reasonable distance from Edinburgh, with a population of approximately 50,000. Inspector Stewart estimated it was 27 miles away. Cumbria Police control room is based at Penrith and covers a town called Barrow in Furness which was approximately 60 miles away, with a population of approximately 67,000. During the Cumbria mass shooting incident (explained in chapter 3) this was within the Whitehaven area and was controlled by the ACR at Penrith. This was approximately 45 miles away. It is common practice throughout UK forces to have Area Control Rooms covering towns some distance away.

9.3.2 Control room staff have access to computer mapping systems which would enable them to view the area. Their process is now referred to as ‘C3’ (Contact, Command and Control). Previously it was called ‘C2’ (Command & Control) throughout the UK.

Prior to the deployment of staff, a risk assessment is required to establish the incident grading, risks and control measures (such as the number and type of officers to deploy). Each incident must be assessed. Police Scotland states that C3 is the "very first line of front line policing playing a vital role in ensuring the service delivers its focus on keeping people safe" [51]

9.3.3 The initial response to a spontaneous incident may be to gather additional intelligence/information[52]. This will assist the commander to decide upon the correct level of response.

9.3.4 Reasonable enquiries should be made before officers engage with a subject, where possible.

9.3.5 The initial direction for response should include initial control measures, such as directing to an RV Point or being clear for officers not to engage with the subject until additional risk and threat are considered.

9.3.6 The ACR performs an initial command function until the command is appropriately transferred to another appropriate person. All staff working within the ACR function perform their function on behalf of the ACR Inspector/FIM. The ACR Inspector is responsible. In comparison, all custody unit staff perform their functions on behalf of the Custody Sergeant. The Sergeant is still responsible for the custody service delivery even if out of the unit.

9.3.7 In this incident there was both an acting Inspector and an acting Sergeant as divisional supervisors. The purpose of acting roles is for officer learning and development.

---

[51] C3 https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.scotland.police.uk%2Fspa-media%2Fgwep0iv0%2Fcontact-command-control-c3-division-national-guidance.doc&wdOrigin=BROWSELINK

[52] https://library.college.police.uk/docs/acpo/Command-and-Control-2009.pdf

Neither officer was 'trained as competent and experienced' in the role for which they were acting. Inspector Stewart would also need to take this factor into consideration, for any handing over of command.

9.3.8 Acting Sergeant Maxwell had 7 years' service at the time of the incident. He had not attended any newly promoted Sergeant training courses prior to this incident. He received mental health training post incident in 2016 and 2017; custody officers' induction in 2017; Acute Behaviour Disturbance (ABD) e-learning in 2017; 2 weeks of leadership training in 2018.[53]

9.3.9 For accessing information for the ACR, they had officers based in the area who they could have consulted with, and members of the public had informed the ACR that a hospital was nearby. The momentum of the incident deployment was being controlled by the Police Constable within the ACR and other ACR staff. They are 'controllers' not commanders. It was clear that this was an unusual Sunday morning incident from the volume of calls being received referring to a knife and a large man who was moving in public spaces. Pausing the incident response to obtain a position statement concerning information would permit a review of the NDM process to establish information/intelligence, threat and risk assessment, powers and policy, contingencies and options, tactical actions and review.

9.3.10 Controllers do not have the authority to deploy and ARV or PSU to an incident, but they can deploy a dog unit.

9.4 If not, would you expect a reasonable ACR Inspector to make; be making or have made, appropriate enquiries from the response team or others as to the nature of the locus? When would you expect these enquiries to be made?

[53] PS00067

9.4.1 As above. I would expect the ACR function to make reasonable enquiries to perform the initial command function. This would include gathering information to establish a risk and threat position and feed into the deployment strategy of who to deploy and numbers, with additional control measures. Although the incident had not been formally categorised on the log as a firearms incident, the ACR staff still made enquiries for dispatching the ARV and two dog handlers. The ACR staff were following some of the basic principles of a firearms incident, or other high-risk incident, without it being declared as such.

9.4.2 The ACR Inspector/FIM is also the on-duty Initial Tactical Firearms Commander. They are responsible for the initial safe management of an incident. A core principle function of the ACR Inspector is to manage and mitigate risk effectively in order to ensure the safety and wellbeing of officers, staff and the public, and to respond effectively to problems, incidents and crime. An ACR Constable is not a Force Incident Manager (FIM) nor a tactical firearms commander. The Constable acts on behalf of the ACR Inspector. The ACR Inspector should be wanting to ensure that appropriate enquiries have been made to develop the tactical plan, for such a high-risk incident. Relevant information would have included knowing what the ETAs of the two dog handlers were; what the ETA of the ARV was; and what level of tactical plan could be safely delivered by unarmed uniformed officers. Safety for all parties must be an overriding priority.

9.4.3 In the initial stages of this reported incident, PC Masterton was the controller and initiated the officer deployment. In his statements[54] there is no explanation of the NDM for the justification of the deployment strategy. Initial enquiries should have commenced immediately to develop the deployment plan and risk-assessment.

9.5 Question 1.4. What conclusion would a reasonable ACR Inspector have reached as to the likely risk (i) to Mr Bayoh; (ii) to any response officers directed to attend the incident; and (iii) to the public; and why?

[54] PIRC-00331 and SBPI-00067

9.5.1 The role of the ACR Inspector is to act as the on-duty supervisor for all contact, command and control. They are a highly trained staff member to ensure that command and control meets the organisation's standards. They have responsibilities which include to manage and monitor operational policing activity, and to effectively and efficiently direct the deployment of resources to incidents. They are responsible for the initial assessment, strategic intervention and management of spontaneous incidents, providing a 24/7 single point of contact for the constabulary in regards to risk and threat management. This risk and threat management includes to the police officers, any subjects, and members of the public, in alignment with all relevant frameworks, policies and procedures. Relevant frameworks to consider would include:

9.5.1.1 Use of force SOP[55];

9.5.1.2 Armed policing Operations SOP [56];

9.5.1.3 Health and Safety SOP[57];

9.5.1.4 Police Dogs SOP[58];

9.5.1.5 Care and Welfare of Persons in Custody SOP[59];

9.5.1.6 Critical Incident Management SOP[60];

9.5.1.7 Officer safety training; and

9.5.1.8 ACR role profiles. (Not yet disclosed to me)

9.5.2 Considering the information available to the ACR function and the ACR Inspector, there is reason to believe a large man in possession of a large knife is posing a threat to himself and others. A knife poses a high level of risk for all persons – to Mr Bayoh, officers and members of the public. Initially, Inspector Stewart was not within the ACR function

[55] PS10933
[56] PS10985
[57] PS11535
[58] PS11344
[59] PS11014; PS17915; PS17918
[60] PS11003

when the calls were being received for deployment decisions, but he was aware a short time before the first officers arrived at scene.

9.5.3 As the most senior commander on duty for the spontaneous response, the ACR Inspector should take initial command of a high-risk incident, until they are satisfied that command is transferred to an alternative, competent, commander or it can be reduced to a standard risk. Although no firearm is confirmed there is reason to consider the possession of a knife as being applicable to manage. This could be managed as per the firearms deployment tactics regardless of whether the incident is declared a formal firearms incident. Two of the three firearms deployment considerations could be considered as being met. These are: “other potentially lethal weapon” and “otherwise so dangerous”. ACR controllers were also complying with some of the firearms operation SOP requirements and were establishing the availability of ARVs and dog units.

9.5.4 Some ACR Inspectors may consider this incident to be a high-risk incident to justify an armed response along with additional specialist resources. The acting Sergeant believed it justified the ARV and dog handler(s) as he immediately requested them to attend. Constables attending also indicated they believed it to be a high-risk incident they were attending. ACR controllers considered it high risk enough to make enquiries to establish the whereabouts of ARVs and dog units.

9.5.5 A knife incident could also be considered as a high-risk public order incident and consideration of the Police Scotland Public Order SOP would be relevant. This permits the ACR Inspector, as commander of a spontaneous incident, to deploy a PSU (Police Support Unit) to an incident. The incident could be classed as a potential ‘violent deranged person’ (VDP). Police Scotland’s position statement dated 7th October 2022 states that a PSU could be deployed in the case of a violent deranged person and that “Where there was an obvious or developing threat or risk at Violent Deranged Person (‘VDP’) incidents and the immediate deployment of public order resources was required, the Duty Officer at Service Overview, Inspector or Police Incident Officer ('PIO') can authorise the

deployment and seek retrospective authority thereafter." An ACR controller is not authorised to deploy a public order response to an incident.

9.5.6 As either a disorder incident, firearms incident or a violent deranged person incident with a knife, the incident is a high-risk incident for the subject, officers and members of the public. The circumstances are still the same. The priority has to remain the preservation of life and a safe police response.

9.5.7 Initial command decisions need to use the NDM to assess threat/risk and the tactical response. Early consideration in both incidents must be given to specialist support such as ARV, dog handlers, PSU, Taser officers and control measures for unarmed uniformed patrol officers.

9.5.8 In circumstances where the incident requires an immediate public order response to deal with a violent deranged person, the ACR Inspector can authorise this.

9.5.9 I was a PSU trained Sergeant, trained for dealing with violent deranged persons with the use of PSU shields. PSU shields should be available within each police area for spontaneous incidents, and used by trained staff. I have deployed as a three person shield team for a man in possession of a weapon in a custody cell.

9.5.10 Regardless of whether the incident was declared a firearms incident or not, it is my opinion that unarmed officers should not have been deployed to the scene without a clear tactical plan from the ACR commander, with clear control measures. The ACR controller should not have deployed them immediately to the scene without direct instruction to only observe. The acting/temporary Sergeant is not trained to the level of the ACR Inspector to command a high-risk incident, and potentially has received no training concerning command and control. The purpose of an acting role is for the person's learning and development. I have viewed the acting Sergeant's training record and there is no record of command and control, or similar training listed prior to this incident.

9.5.11 The acting Inspector, Inspector Kay, is not trained to the standards of the ACR Inspector, and initially is not involved in the incident deployment. The initial deployment is made by ACR controller PC Scott Masterton with requests being received from acting Sergeant Scott Maxwell. Acting Inspector Kay's first entry on the log is at 07:20:56, approximately 33 seconds after the arrival of PC Paton and PC Walker.

9.5.12 Inspector Stewart, in his evidence, made the following statements:

9.5.12.1 "I had overview of the whole service centre and the area control room, so my responsibility was to make sure that calls were resourced and attended by local policing officers, by specialist resources if required."

9.5.12.2 "depending on the information that was passed, but if there was any threat, risk of harm then I would suggest it would always be a grade 1 call."

9.5.12.3 "I think someone in possession of a knife is always going to be a grade 1 call, just because of the potential risks associated with someone having a weapon in a public place."

9.5.12.4 "If there was weapons involved, the level of risk would be higher potentially and then the overall harm that could be done. So a threat, risk and harm risk assessment is probably a good way to describe it."

9.5.12.5 Concerning acting Sergeant Maxwell's involvement "I would certainly take into consideration his views and thoughts" and "he can request an ARV, but ultimately on that day it was myself as a trained tactical firearms commander who would be the individual who authorised and deployed armed -- ARVs to an incident."

9.5.12.6 "We always had an ITFC as a duty officer, they went hand in hand, because you were that initial sort of response, or assessment for serious incidents involving firearms or weapons, or violence. So if an incident came into the control room in terms of a live incident, someone in possession of a handgun, someone in possession of a knife or an axe, I would make that determination based on my training as to whether or not it was a declared firearms incident."

> **9.5.12.7** "It would be threat, risk and harm facing members of the public, that would be my consideration, but I would use a model, a national decision-making model which as a firearms commander I was trained to use to understand an incident, what was happening, what the threats could possibly be, who was involved in the incident. It's about making an initial risk assessment, a threat assessment which is prioritised, and then I work through various sections of it covering sort of policy and powers, the criteria for the deployment of armed officers, whether or not that's met, and then I would work through the various tactical options that would be available to me."

9.5.13 In conclusion, concerning what a reasonable ACR Inspector would do, I take into consideration what Inspector Stewart also states and conclude that the reasonable ACR Inspector would follow the NDM process prior to any resources being deployed to the incident. The NDM would have identified risks and threats and also contingencies. The ACR Inspector would have made the tactical deployment plan in line with their incident management training, recognising that a man armed with a large knife is a risk to himself, unarmed officers and the public. Controllers have brought the incident to his attention due to the risk they fear, and enquiries have been made to establish the location of ARVs and dog units. There was a quick decision required from the ACR Inspector concerning whether to let patrols continue to deploy without a tactical plan, or intervene. Rapid decisions for spontaneous incidents is common practice for ACR Inspectors with the level of training they receive to ensure that risk is mitigated with the tactical deployment plan. Unarmed officers should not attempt to detain an armed subject and the initial priority if a member of the public was not in immediate risk was to clearly instruct officers to maintain distance and conduct observations (as explained earlier). This would provide the ACR Inspector with additional time to consider the NDM.

9.6 How would that assessment inform a reasonable ACR Inspector's decision making in terms of (i) the categorisation of the incident, (ii) the resources to be allocated to the incident, and (iii) the ongoing management of the incident?

9.6.1 I have never been a Control Room Inspector, but I have trained Control Room Inspectors and staff, for command and control and major incident command.

9.6.2 The ACR Inspector's role is to initially assess all operational spontaneous incidents, and using the NDM to form the initial tactical plan. This will include who to send, in what capacity, and how many to send. They are also to consider contingencies which can include the consideration of medical support in case of physical injury being sustained. As stated by Inspector Stewart in his oral evidence [61]: "We always had an ITFC as a duty officer, they went hand in hand, because you were that initial sort of response, or assessment for serious incidents involving firearms or weapons, or violence. So if an incident came into the control room in terms of a live incident, someone in possession of a handgun, someone in possession of a knife or an axe, I would make that determination based on my training as to whether or not it was a declared firearms incident".

9.6.3 In this incident, Inspector Stewart did not make that initial determination as he was not present. PC Scott Masterton made the deployment decision.

9.6.4 Considering all the above factors I am of the opinion that the ACR Inspector, if present, would have maintained the initial command role; categorizing it as a high-risk emergency incident; ensuring that officers trained and equipped to deal with such incidents were located and deployed and not allow unarmed uniformed officers to arrive sporadically as they did. PC Masterton made the decision on behalf of Inspector Stewart to deploy unarmed uniformed officers directly to the scene without a tactical plan of them being told to observe and report back.

9.6.5 The ACR should have access to information to allow them to know which disciplines were available within their policing area such as ARV, dogs, PSU, Taser.

---

[61] Line 14 Page 145 Day 5 transcript

Two dog units had been directed to attend and the ARV had been communicated with. Another option would be, for the ACR staff to seek advice from an emergency planning advisor if one was readily available. As a Sergeant within Cumbria's emergency planning team I would regularly provide advice to the on duty commander for a range of incidents, which included the spontaneous firearms incident of the 2010 Derick Bird mass shootings. I also facilitated the multi-agency command and control debrief of the incident response. We operated our emergency planning unit over a 7 day period for weekend cover. I do not know if an emergency planning team were readily available on this date.

9.6.6 I am of the opinion the reasonable ACR Inspector would take all of the information into consideration and if unarmed officers were to be used, they would be deployed to an RV point initially with a direction to observe and report back until contacted specialist resources, for example the dog handlers, could be confirmed for estimated times of arrival. If observations indicated the risk too high to wait, a deployment strategy could then be managed with a co-ordinated team approach.

9.7 How would a reasonable ACR Inspector have categorised the incident (in particular: Grade? Firearms? Critical?); and why? When would a reasonable Inspector have taken this decision vis-à-vis the arrival of the response team?

9.7.1 In 2011 the National Police Improvement Agency (NPIA) released the National Standard for Incident Recording[62] (NSIR) guidance. This aimed to support improved identification and management of risks, threats to safety, vulnerability and repeat victims, particularly in relation to Anti-Social Behaviour (ASB). The principal aim of NSIR is to ensure that incidents are risk assessed at the earliest opportunity leading to an appropriate response. From the first point of contact, identification and management of

62 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/116658/count-nsir11.pdf

risk is crucial to delivering an appropriate police response. Police Scotland also have a comparable national incident recording standard, with listed categories.[63]

9.7.2 A grade 1 incident throughout the UK police is comparable. As explained earlier in my report, a grade 1 incident grading applies where there is:

9.7.2.1 an immediate threat to life;

9.7.2.2 a serious crime is in progress or likely to occur or a suspect for a serious crime is present or nearby;

9.7.2.3 to allow evidence of a serious crime to be secured, that would otherwise be lost;

9.7.2.4 a road traffic collision involving personal injury has occurred;

9.7.2.5 where a person who is especially vulnerable needs urgent assistance; or

9.7.2.6 the person receiving the call assesses that an immediate response is required.

A grade 1 call will also be subjected to target times, however a target time does not mean that risk assessment is compromised, and if justified a grade 1 call can be delayed.

9.7.3 I am of the opinion it would have been a grade 1 emergency call, high-risk, and marked for weapons. It is unlikely to have been endorsed as a critical incident by ACR staff during the spontaneous management, but the ACR Inspector should be considering such SOPs, due to their enhanced level of training. Police Scotland position statement of October 2022, concerning critical incidents, stated that:

9.7.3.1 "The definition was deliberately broad and designed to ensure that any potentially critical incidents were not missed. The definition encompassed not only major incidents and serious crimes that may immediately have been identified as "critical", but also, less serious incidents or criminal acts which could have had a significant impact. This was because officers and staff are required to consider the impact of crimes and incidents on victims, their families and the wider community,

[63] See Appendix M

in order that an appropriate response was provided and confidence in policing maintained"

9.7.3.2 "It is important to note that a critical incident could occur at any time in any context, in any department or unit and may have been assessed as critical even when the initial event did not appear significant. Early intervention could prevent escalation of an event to a critical incident"

9.7.3.3 "A risk management or assessment tool was contained within the SOP to assist with the decision making process around critical incidents" Section 3.4 of the critical incident management SOP states that "staff must ask themselves what am I dealing with? What might develop? What is the potential impact of this incident and/or police response to it? What is the perception of those involved? What are the expectations of those involved? Are their expectations proportionate and realistic? Who do I contact should I suspect I am dealing with a potentially critical incident?" A specific incident example is that of an incident which requires a specialist police response. Generic factors would include incidents where the police may be responsible for the death or serious injury of the victim or offender; Incidents which attract high profile media attention.

9.7.4 Section 4 of the Critical Incident Management SOP identifies that call takers and staff within the control rooms may identify a potential critical incident and that their initial decisions may safeguard community confidence. If identified staff are to notify either the patrol Inspector i.e. Inspector Kay or the ACR Inspector, Inspector Stewart. Whilst any officer may identify a potential critical incident that suspicion must be raised up the command and control chain – to an officer of Gold command level, which is a minimum of Chief Inspector or above. In this incident the ACR commanders are trained to identify potential critical incidents as early as possible, mark the log, and notify a senior officer for their assessment. The command and control incident log should reflect the decision to declare as a critical incident at the earliest opportunity. Certain incidents require mandatory notification up the command chain such as incidents graded as firearms, terrorism, kidnap, police pursuits, and murder. The ACR Inspectors receive additional training to consider incidents which may initially not meet the mandatory referral but due

to other factors need to be notified upwards such as a missing child, a school bus collision, a high risk absconder, or an incident which may develop to a confirmed firearms incident. Training emphasis is to err on the side of caution and notify upwards rather than to delay notification.

9.7.5 Section 6 of the Critical Incident Management SOP identifies the IDR process. This stands for 'Identify, Deal and Refer'. Inspector Stewart referred to this process during his evidence. 'Identify' means to undertake an initial risk assessment and identify criticality factors. 'Deal' means to take appropriate steps to deal with the incident following relevant protocols. 'Refer' means refer the incident to a line manager.

9.7.6 Section 8 of the Critical Incident Management SOP refers to the fact that all decisions made should be using the National Decision-Making Model.

9.7.7 The Critical Incident Management SOP states that all officers should be provided with training. The ACR Inspector should have received training concerning this subject matter. Acting Sergeant Maxwell's training record and the Constables attending the scene, do not show critical incident management training, however this may have been incorporated into other training. Records do not show that acting Sergeant Maxwell had received any PSU training, which if he had it would have covered mutual aid standards training incorporating dealing with a violent deranged person. (At this point I do not have the training records for Inspector Stewart or acting Inspector Kay.)

9.7.8 The Critical Incident Management SOP is not intended to undermine or replace other guidance but is an additional resource to support officers. This SOP identifies the risk management tool which is commonly referred to as the '5x5' risk assessment. I have been teaching the 5x5 risk assessment model since prior to this incident. It works on a scale of 1 to 5 for likelihood, multiplied by a scale of 1 to 5 for severity. This provides a risk score out of 25. The process can be subjective based upon an officer's knowledge and experience. The matrix is then coded red, amber and green. A score of 11 to 25 requires immediate action and consideration for onward referral as a critical incident.

Considering the scenario of a man armed with a knife, moving through a residential community and chasing moving vehicles which has resulted in multiple people calling 999, this would indicate an incident which may impact upon the community confidence with the police. A score of 3 would indicate it is as likely to occur as not to occur. My opinion is that such an incident would not be assessed lower than a three. Considering the impact of such a scenario you would also need to consider the community impact - if the area is commonly having such incidents or whether they are rare. If they are rare, the community may be more impacted by the event. If it was considered to be an impact of 3 this means a "significant impact to local community, individuals and their confidence in the police response". 3 x 3 gives a risk score of 9 which means "Review current status, actions and interventions asap. Consider referral upwards." Any increased consideration for likelihood or impact would place the risk score at 'red' and require "Immediate action required. Refer upwards. Consider CI."[64]

9.7.9 As a high-risk incident involving a knife an ACR Inspector would be expected to consider specialist resources such as ARVs and whether the incident required to be declared a firearms incident. Firearms teams were available at Edinburgh, Stirling and Edinburgh Airport. Inspector Stewart estimated an ARV would take around 25 to 30 minutes to arrive at scene. There was also an operational firearms commander available who advice could be sought from. Two dog handlers were also directed by ACR staff to attend.

9.7.10 Any police response to a high threat incident should follow safe response procedures. These procedures are also applicable to incidents without a firearm, where the incident is considered to be otherwise so dangerous, but is not assigned as a firearms incident. This incident was considered unusual regarding the volume of calls, and the fact all available resources were being deployed, with the acting Sergeant requesting firearms and dog handler.

---

[64] CI – Critical Incident

9.7.11 Inspector Stewart stated in oral evidence that Ms Michelle Hutchison, ACR communications officer, was the person who communicated with the operational firearms commander on the date. At this time I have not viewed a statement from Ms Hutchison concerning why she believed it necessary to contact the operational firearms commander. It is not common practice to contact the ARVs concerning incidents, unless you believe it may be a firearms incident and/or it is an incident requiring their specialist discipline. Ms Hutchison would not officially be able to deploy an ARV to an incident as the authority is required to be from the ACR Inspector.

9.7.12 In light of the information available to me my opinion is that a reasonable ACR Inspector, had they been involved from the beginning, would have declared it a grade 1 incident, responded in line with the Armed Policing Operations SOP and performed as the Initial Tactical Firearms Commander to deploy resources as part of a co-ordinated tactical plan. Also initiating the informing of a Chief Inspector, or above, concerning a potential critical incident. Constables would have been instructed to not engage with Mr Bayoh.

9.7.13 Inspector Stewart stated in oral evidence: “Your working strategy would then go on to cover, you know -- you would want it to locate -- identify and locate and contain the individual, search -- stop them, search them, recover any weapon and then return to normality so that working threat and risk assessment would change throughout the course of an incident if it was longer.”

9.7.14 Although the issue of terrorism has been raised during the evidence, it does not appear to have been a consideration by the ACR team. Acting Sergeant Maxwell stated he had considered it, but discounted it. In my opinion a terrorism incident on the critical incident management scale would be 5 x 5 with a risk score of 25. The terrorism level was deemed to be ‘severe’. There are five levels of threat for the UK:

1. Low - an attack is highly unlikely.
2. Moderate - an attack is possible but not likely.

3. Substantial - an attack is likely.
4. Severe - an attack is highly likely.
5. Critical - an attack is highly likely in the near future.

[redacted].

9.7.16 Assistant Chief Constable Bernard Higgins had released a digital recording [65]to Police Scotland officers which was 3 minutes 40 seconds in duration, explaining that a lone individual carrying out a low sophisticated attack was the incident assessed as being the most likely incident to occur. This in mind, and considering emergency planning, I have not had disclosed to me any Police Scotland plans for how to deal with an incident which is considered to be such an act. If plans did exist they should be readily available by the ACR staff, and the content known. The ACR staff should then take these plans into consideration, and these will indicate the command structure for such suspected incidents.

9.8 What resources would a reasonable ACR Inspector have deployed to the incident and why?

9.8.1 UK Police forces maintain standard tactical response disciplines. For example, they have available ARVs, dog handlers, PSU and Taser capabilities. These may be a mixture between officers deployed in those roles as their full tour of duty, or available to deploy from other duties to that role. Inspector Stewart stated “the controller's got responsibility for looking at the resources, looking after them”.

[65] PS01319

9.8.2 The initial request from acting Sergeant Maxwell for ARV and dogs was at 07:17:23 and then repeated for an update at 07:19:17. These were both made prior to the arrival of the first police vehicle at scene, at 07:20:23. In response to the 07:19:17 request, PC Scott Masterton replied “I believe a dog unit is en route”. Ms Hutchison then stated: “Be aware, organizing an ARV as well”.

9.8.3 Inspector Stewart stated that he was involved listening to the transmissions from a time between 07:18 and 07:20, having been elsewhere in the control room. The first emergency call was received by the ACR at 07:10:14 indicating that Inspector Stewart missed approximately 8 minutes of the incident process. I am unaware if ACR staff attempted to engage him for the incident during this time.

9.8.4 Upon his return to his desk Ms Hutchison commenced briefing him, in addition to his self-briefing.

9.8.5 Inspector Stewart stated: “I felt on this particular incident waiting wasn't an option on that morning because someone was reported to be carrying a knife in a public place at 7 o'clock in the morning and we were just unsure what was going to happen”. There is no evidence provided concerning the use of the NDM for this decision. There is a risk when a person is carrying a knife in public but this must be balanced against the risk of deploying unarmed officers to the scene and the risk they will then face. There is also a risk of dispersing the person with the knife if they cannot be contained and detained. This dispersal may then increase the risk to the public as the person may flee in a state of panic.

9.8.6 Inspector Stewart stated that deployed officers arriving “could have paused and assessed the circumstances, wait for back up.”

9.8.7 Inspector Stewart stated “I suppose I would have expected them to go and -- if someone was reported to be in possession of a knife, to stop short, slow up and provide

that update, not just to myself in the control room but to colleagues that were attending as well, and to supervisors as well, but I don't know the circumstances of that day."

9.8.8 In my opinion, taking into consideration all information including the knife and the various SOPs, the reasonable ACR Inspector would deploy unarmed, non-specialist staff with clear direction to not engage with the subject – to keep distance, observe and feedback. Specialist staff such as the ARV/Taser, dog handler(s), and PSU staff would be the preferred response considerations. The ACR staff had already made contact with dog handlers and ARV prior to unarmed local staff arriving. Deploying staff to an allocated RV point would allow for a tactical plan review, and to agree operational command. The dog handler, PC Gary Wood, stated[66] he could have arrived within 10 to 15 minutes of initial deployment. Using a dog is a use of force tactical option available for the ACR to deploy to such an incident. As part of my previous PSU training, I have trained alongside dog units to deal with disorder and violent people. Deployment of a dog unit does not necessarily mean the dog is used against the subject. The mere presence of a dog can bring an incident to a rapid conclusion without physical force being used, the person typically becomes passive and allows handcuffing to take place. The Police Scotland Police Dogs SOP[67] has been disclosed to me and this includes the following statements:

9.8.8.1 Section 2.3 explains dog units can be deployed to protect life "deterring offenders who pose an immediate threat to the safety of others" and preventing escape. The incident occurring in a public place meant that multiple escape routes existed with insufficient staff available for a containment. One dog can locate and prevent an escape.

9.8.8.2 Section 5.3 states that a dog unit can be used for control and/or containment of spontaneous disorder.

9.8.8.3 Section 5.4 states that the dog unit can be used to detain an armed/violent person.

---

[66] SBPI-00108
[67] PS11344

In my opinion the dog handler was the reasonable tactical option to wait for, and the time to wait was approximately ten minutes. Unarmed officers could have been deployed to an RV point to monitor/observe and report back. The decision to continue to use the unarmed officers should be subject to the NDM process, and in light of no immediate threat to life the necessity to immediately engage was not present.

9.8.9 The 2011 ACPO Police Dogs Manual of Guidance[68] is referred to within the Police Scotland SOP. This guidance is a 339 page document concerning the use of police dogs.

9.8.10 The advantages of using a police dog to detain a suspect in possession of a knife, or other weapon, can minimise the risk of stabbing injuries to officers and the subject. Physical restraint injuries can be negligible. The most likely injury for a suspect to risk the experience of would be a dog bite.

9.9 In your opinion, would a reasonable ACR Inspector require feedback from response officers dispatched to the locus in order to complete his assessment as to the appropriate categorisation of the incident, and the resources and management it required? How long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? How long would a reasonable ACR Inspector take to implement any such steps?

9.9.1 Police managers and ACR staff regularly have to use the NDM process for deployment decisions without being able to see the scene, for example the Cumbria shootings. It was not necessary to receive feedback before making a decision to engage specialist resources such as the police dog. There was sufficient information from several members of the public concerning a large knife and a large man from which to make an initial threat and risk assessment. Officers attending the scene and providing feedback

[68] https://www.npcc.police.uk/documents/uniformed/2011/201103UOPDogsMoG1.1.pdf

was not necessary in order to complete the initial categorisation of the incident and initial resource decisions. Safety of all parties and the preservation of life must always be a priority for incidents.

9.9.2 Any feedback required should be additional information. Clear instruction should be provided to unarmed officers to maintain distance and not engage with a subject, and only provide information back to Control concerning the incident. Additional information would assist the tactical plan to reduce risk, but the tactical plan can be formed assuming the risk is present.

9.9.3 ACR Inspectors are trained to take initial command of high-risk and rapid incidents which include firearms incidents and vehicle pursuits. The NDM is a process used within the police service for spontaneous and planned incidents. Risk must always be balanced, and if the initial commander requires additional time to make those decisions, it is reasonable to not place officers into the incident. Officers can be informed to 'standby' and wait for deployment tactics. As a knife incident this is a high risk incident. Regardless of whether or not the incident is formally declared a firearms incident it still requires significant management and control strategies, with a deployment strategy. The fact that dog handlers and the ARV had been contacted indicates that the principles of the firearms incident response were being considered by the ACR team, but only the ACR Inspector could declare it as a formal firearms incident. The controllers cannot declare it a firearms incident. In my opinion the methodology for dealing with the incident is more important than the computer system grading being allocated. This incident was considered unusual by staff on duty due to the time of day and the volume of concerned members of the public. Multiple reports stated there was a large knife involved. The ACR Inspector should be mindful of the Firearms SOP, the Critical Incident Management SOP, Police Dogs SOP, Health and Safety SOP, and the Care and Welfare of Detained Persons SOP. If the ACR Inspector needed more time to consider the strategy, a reasonable Inspector would abort the arrival of officers. Ultimately, lives are at increased risk if there is no tactical plan.

9.10 If response officers were already en route to the locus by the time a reasonable ACR Inspector learned of the incident, how long would a reasonable ACR Inspector wait for feedback? In the absence of feedback, what steps would a reasonable ACR Inspector take to seek or secure that feedback? In the absence of any feedback, how long would a reasonable ACR Inspector take to implement any such steps?

9.10.1 Commonly, officers will update upon their arrival to indicate, as a minimum, "at scene" and should be updating what they immediately see in order to update control and other officers attending. The lack of feedback from a scene can indicate a significant risk/threat. There is no time limit, but a lack of immediate feedback can indicate there was a lack of opportunity to update control. This should feed back into the NDM.

9.10.2 The initial incident commander, can direct responding officers to divert from an incident, if they believe the risk is too high until a tactical plan is prepared. Officers attending a high-risk weapon incident, who then fail to update control, could indicate a severe risk/threat has been encountered. The reasonable Inspector should take this factor into consideration for their tactical plan, and creation of an increased response.

9.10.3 Having deployed officers to a high-risk incident, who then fail to make contact with Control could indicate a serious incident has occurred. To continue to send officers sporadically to the scene could place additional officers at risk. A co-ordinated arrival would be essential.

9.11 What directions, if any, would he have given to those officers and when?

9.11.1 The ACR Inspector is the initial commander of the incident, and responsible for the safe deployment of resources. The ACR Constable had deployed the officers directly to the scene without the knowledge of the ACR Inspector. As the FIM, the ACR Inspector could have immediately informed officers to "abort" or words to that effect. The benefit of repeating a single word is that officers are more likely to hear a repetitive single word, rather than a lengthy statement.

9.11.2 The first officers attending should have been clearly informed to abort and not to engage with the subject, to pass information, and RV with officers at a nearby nominated location. This would then allow the ACR Inspector to decide their initial tactical plan, gain additional information and establish the ETA of the dog(s).

9.12 (Depending on your view as to how a reasonable ACR Inspector would have categorised the incident as firearms, critical etc) What procedures and steps would then have been implemented to manage the incident?

9.12.1 This was a high-risk weapons incident. Any police response to a high threat incident should follow safe response procedures. These procedures such as the Armed Policing SOP and Police Dogs SOP are also applicable to incidents without a firearm, where the incident is considered otherwise so dangerous, but is not assigned as a firearms incident. Safe procedures include the fact that unarmed officers should not approach or detain the subject.

9.12.2 The reasonable deployment would have been to deploy officers to an RV point under directions to observe and feedback. This would then inform the tactical deployment plan and allow time to establish the ETA of the dog handlers. A person ‘on the move’ in a community open space is difficult to contain by two officers and could easily displace the risk to another location. The use of the police dog was a reasonable option to attempt to wait for. Had the public then been seen to be endangered, officers would need to respond to that threat, but the necessity to immediately engage was not present. Police officers routinely put their safety, and lives, at risk when a member of the public is endangered, but at this time no member of the public was actually under immediate threat of harm.

9.13 Please describe the roles and responsibilities of the various personnel who would have been involved in the command and control of the incident, with

particular reference to (i) the ACR; (ii) senior officers within Fife Police and Kirkcaldy Police Office; and (iii) individual response officers.

9.13.1 In addition to what has been previously explained, the ACR Inspector is the initial commander for incidents. They have a team of staff within the ACR who can then be assigned to gather additional information and intelligence. ACR staff should be locating information for deployment considerations, such as which officers are on duty, or on call, for specialist roles. ACR staff work on behalf of the ACR Inspector. ACR staff are controllers and the ACR Inspector is the on-duty commander. No ACR staff can assume the formal role of commander.

9.13.2 A senior officer will always be available to act as Gold commander for major/critical incidents. That senior officer may not be actively listening to the airwave terminal, but the ACR should have a register to know which senior officer is available.

9.13.3 The local Sergeant and Inspector would be assigned as PIOs (Police Incident Officers) within Bronze command, for delivery of the tactical plan. Point of note for this incident is that the on duty local Inspector and Sergeant were both ‘acting’ ranks and not trained to the level of the ACR Inspector. Both acting officers were gaining experience for the rank, and not yet trained to hold the rank.

9.13.4 Response uniformed Constables carry out the tactical plan. They should be appropriately briefed concerning the plan, including control measures. The officers still have professional autonomy at the scene of an incident to achieve the tactical plan, but in light of new information they need to continually use the NDM to reassess threat/risk and tactical options.

9.14 In your opinion, had the incident been declared a firearms incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a firearms incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).

9.14.1 Had the incident been declared a formal firearms incident from the beginning, the ACR Inspector would have formally been the Initial Tactical Firearms Commander and formally responsible for the formal tactical plan. He would have mandated actions to consider, including to inform unarmed officers not to engage with the subject. I believe he would have clearly informed the Constables to 'abort' their arrival, as that is out with of the formal response to a firearms incident.

9.14.2 Local officers should have been aware to not engage with a subject if the incident was formally declared a firearms incident. The emphasis would be on observations from a distance and reporting back to ACR.

9.14.3 If after officers had arrived, the incident was then declared to be a firearms incident, officers at the scene should have retreated from the subject and taken tactical direction from the ACR Inspector. The ITFC is also likely to instruct the officers to retreat from the scene.

9.14.4 Alongside of declaring a formal firearms incident the Inspector should also be thinking 'Critical Incident', having the STORM log endorsed with both phrases and the on-duty Gold commander notified.

9.15 In your opinion, had the incident been declared a critical incident, what difference (if any) would that have made to the outcome? Please explain whether your views would alter, depending on whether a critical incident had been declared at an early stage (prior to the arrival of officers at Hayfield Road) or at a later stage (after their arrival).

9.15.1 The ACR Inspector can declare an incident a possible critical incident but a Gold commander needs to formally declare it a critical incident. Declaring an incident a possible critical incident would not necessarily alter the actions of the attending officers, as incidents without violence can also be critical incidents. However, all firearms incidents can also be declared a possible critical incident. Staff know that any incident declared

formally as a critical incident is subjected to a debrief process so all involved staff actions/lack of actions will be reviewed. If staff were informed this was a firearms and possible critical incident there would likely be an unconscious understanding amongst officers that this was an increased high-risk incident, and an incident which would be reviewed in detail. Staff are likely to be more mindful of entries they wish to be recorded on the log.

9.15.2 Any officer can report their belief that an incident should be declared a critical incident, but that belief should be reported to the ACR Inspector who then informs the senior officer on duty for formal agreement. Some incidents such as a firearms incident or death in custody are expected to be declared critical incidents, and the ACR Inspector is the person most likely to be trained to be consciously aware of these factors. Firearms incidents and critical incidents attract senior officer scrutiny, and debriefing, so actions/lack of actions are reviewed. As explained in chapter 3 of my report, the school bus collision, which I was involved with, was immediately declared a critical incident due to the fact the passengers were all school children and the likely increased public and media interest such an incident would create. This was declared before it was known that two of the children died. Numerous traffic collisions occur daily but are never declared critical incidents. This indicates how the concept of ‘unusual’ is taken into consideration.

9.15.3 If the ACR Inspector was thinking about critical incident management they would be conscious that their decision-making is likely to receive additional enhanced review, and as a result may be more mindful for the recording and justification for all options. Commonly a controller is allocated to be the scriber for the ACR Inspector to ensure timely and detailed recording of decision making.

9.15.4 In summary, the incident is not likely to be declared a critical incident prior to police arrival, but the ACR Inspector should be considering it as a potential critical incident, since a more senior officer will be required to officially declare it as a critical incident.

10 Question 2A - Risk assessment: En route to the locus

- **10.2 In light of the information known to the attending officers (airwave transmissions; terror threat level; day and time of call; proximity of locus to residential area, hospitals etc), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **10.3 What conclusion would a reasonable officer have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **Why?**
- **10.4 How would that risk assessment inform the available tactical options?**

10.1 General Information

10.1.1 Relevant information and guidance to consider concerning risk assessment and being en route to an incident would include:

10.1.1.1 Information being received from the public;

10.1.1.2 Officer safety training concerning knives;

10.1.1.3 Armed Policing Operations SOP[69];

10.1.1.4 Police Dogs SOP[70];

10.1.1.5 Estimated time of arrival for specialist resources;

10.1.1.6 Number of officers being deployed to the incident;

10.1.1.7 Knowledge, skill and experience of officers being deployed to the incident;

10.1.1.8 The current terrorism threat level, if considered applicable;

10.1.1.9 Person(s) involved as potential subject. Their profile such as young/old, male/female, large/small, intoxicated/not intoxicated, mental or physical illness,

[69] PS10985
[70] PS11344

means of escape, intent to harm persons and/or property, access to weapons or vehicles;

10.1.1.10 Objects involved – known or suspected weapons;

10.1.1.11 Place – particular vulnerabilities or considerations such as near to a hospital or other vulnerable locations; near to roads, trains or water; and

10.1.1.12 What the tactical plan is – has a tactical plan been relayed to attending officers.

10.1.2 The ACR needs to update deployed officers with relevant information for their safety, the safety of the person they are being deployed to (the subject) and the safety of the general public. Patrolling Constables are reliant upon the ACR staff conducting initial risk assessments and threat assessments, and considering the NDM before they are deployed. Being deployed indicates that the initial NDM process has been conducted and the officer continues with the NDM process. The NDM process is required for all incidents. The ACR NDM process for a high risk and grade 1 incident is overseen by the ACR Inspector but can be conducted by the controller on the Inspector's behalf unless it is a mandatory ACR command incident such as a firearms incident. Circumstances where there are foreseeable risks include dealing with violent people and custodies[71]. To meet the commitment to health and safety there is a requirement to identify risk, assess tactical options, remove risk where possible, adopt control measures and precautions[72]. Individuals are required to report any situation to a supervisor which has the potential for serious or imminent danger[73].

10.1.3 On receipt of a suspected firearms incident the controller must bring it to the attention of the ITFC[74]. The incident was not immediately brought to the attention of the ITFC (Inspector Stewart), but ACR staff did make enquiries concerning ARVs and dog units in line with a firearm incident response. This incident was brought to the attention of

[71] Health & Safety SOP PS11535 section 4J

[72] Health & Safety SOP PS11535 section 4N
[73] Health & Safety SOP PS11535 section 7.2
[74] Section 9.4 Armed Policing Operations SOP

the ITFC a short time before officers arrived. The ACR Inspector would have to make a rapid decision using the NDM and considering all of his training. The ACR Inspector was physically overseeing the incident prior to officer arrival, and therefore responsible for officer, subject and public safety.

10.1.4 It would be reasonable for the initial officers to believe the NDM process has been conducted and the ACR Inspector is fully aware of the incident they are being deployed to.

10.1.5 All officers and staff are trained to use the NDM.

10.1.6 Officers are trained in order to deal with their stress to utilise their relevant training and experience. Police officers must routinely make difficult decisions in spontaneous and fast-moving incidents. Information is regularly incomplete and officers have discretion concerning their use of powers.

10.1.7 Officers are trained to understand policing priorities include the preservation of life, and that any use of force must be justified as being necessary, reasonable and proportionate to the threat/risk.

10.1.8 Officers are trained in the function and use of all personal issued equipment and technology. Officers should be in possession of all authorised PPE when on duty, and if they are unable to be so, they must formally report the matter for a local management decision to be made. Spare uniform and equipment is commonly held in force and can be dispatched to officers.

10.1.9 Officers are familiar with working alone, and as part of a team. They are taught the rank structure and the basics of incident command and control. Individual officers then receive additional training and experience subject to their career path.

10.1.10 High-risk incidents are not uncommon. Some high-risk incidents are considered to be intolerable. For example, a firearms incident where a firearm is believed present and the officer is unarmed, and has no personal protective equipment to deal with the threat to them. Control measures are steps which can be taken to lower the risk/threat.

For example, the passing of information to the control room of the situation may instigate the order to retreat from the incident, but likewise the officer(s) have discretion to retreat to a safe place if they believe the risk/threat is too high. There is no policy which mandates an officer to give their life to protect a member of the public.

10.1.11 Officers are trained concerning firearms and knife awareness, and the basic stay safe action plan.

10.1.12 All officers must meet the standards for the safe use of equipment which they carry. For example, officer safety training to use their baton, handcuffs and spray. All officers should have the basic first aid training to cover responding to casualties and performing CPR. Other officers will have additional first aid training comparable to the one-day civilian emergency first aid at work or the three-day first aid at work. Specialist roles will receive additional specific first aid training.

10.1.13 En route to any incident officers must consider the NDM, review what information has been provided and can ask questions of the ACR, or provide local knowledge to them for the ACR's risk assessment. Officers can ask what the incident has been graded – such as terrorism, firearms, public order. Officers could also give their opinion concerning the deployment and could request an RV point is agreed for staff to meet and agree the subject approach. Ultimately the initial incident management rests with the ACR and the ACR Inspector as the FIM and incident commander.

10.1.14 In this incident officers are aware that this is a grade 1 emergency call and there are reports of a man with a knife in a public place. Officers should feedback to ACR any local relevant information such as vulnerable sites of hospitals.

10.1.15 The first information provided over the airwave terminals is at 07:16:32 when PC Scott Masterton informs officers "I need you to divert…". Patrol officers would not be aware, at this time, that the ACR Inspector is not involved in this decision-making for deployment. Being informed to divert from one incident to another indicates that the new deployment is of a higher priority.

10.1.16 The first emergency call was received by the ACR at 07:10:14. This call was made by Mr Harry Kolberg. He reported to police that a man was about 6 feet tall, “quite big built” and “quite muscly built” and “It looked as if he was actually carrying a knife and he started chasing the car.” This call was graded as a priority 2 incident by, it appears, the call handler. Priority 2 would mean that a response is not required immediately. My opinion is that this grading is wrong, it should have been graded as a priority 1 incident from the first call due to the belief a knife is involved, and the person was in the carriageway. Additional description of the calls can be referred to within this report. Over the next 6 minutes, before officers are deployed, other emergency calls are received concerning a man with a knife. In my opinion 6 minutes from receipt of the initial call until the entry is made appears to be an unnecessary delay, and I am currently unaware of the reason for the 6 minutes. Phrases such as “huge blade”; “9 inch blade” and “big kitchen knife” are used which would reinforce the belief that the incident is genuine and a large knife has been seen. Mr Pearson, when he calls also reports that this incident is near to the hospital, so the ACR staff are aware that there is a hospital nearby. Mr Kolberg also makes a second call and reports it is near to the hospital.

10.1.17 When officers are informed to divert it is 07:16:32 and 4 seconds later at 07:16:36 the call is received from Linda Limbert who reports “he's carrying a huge big big knife”.

10.1.18 By this point at the latest, and prior to the officers arriving, it is my opinion that the significant risk and threat for this incident should be recognised by the ACR staff. At this point of deployment the ACR Inspector is not, apparently, aware of the incident or the officer deployment. In view of the Inspector’s absence either he should be located, or his deputy should be reviewing the deployment. In my opinion, by the receipt of Ms Limbert’s call the officers should be stopped from attending the incident until the ACR Inspector/Initial Tactical Firearms Commander/Force Incident Manager reviews the NDM for the deployment tactics. This is the final ‘trigger point’, in my opinion, for the ACR Inspector to review and make the initial command and control decision concerning whether this should be formerly classified as a firearms incident. Inspector Stewart believed he was in the ACR, somewhere, but was unaware of the incident unfolding. The ACR staff should have brought this incident to his attention before now for his

involvement. The Armed Policing Operations SOP states that controllers must bring suspected firearms incidents to the attention of the ITFC immediately. As ACR staff are locating ARVs and dog units this suspected firearms incident should have immediately been brought to the Inspector's attention.

10.1.19 As mentioned above, the officers being deployed will likely be of the opinion that the ACR Inspector is aware and has sanctioned their deployment to such an incident.

10.2 In light of the information known to the attending officers (airwave transmissions; terror threat level; day and time of call; proximity of locus to residential area, hospitals etc), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?

10.2.1 A reasonable officer being deployed should now be using the NDM and gathering as much information as they can about the incident. In the initial stages they are heavily reliant upon the ACR giving them the information and any deployment tactics. Between 07:16:32 and arrival at 07:20:23 this gave attending officers approximately 4 minutes to prepare themselves for arrival at the scene. This involves:

10.2.1.1 Intelligence/information;
10.2.1.2 Threat/risk and develop a working strategy;
10.2.1.3 Powers and policy;
10.2.1.4 Options & contingencies; and
10.2.1.5 Actions.

Ultimately officers need to act within their organisation's code of ethics and values, such as being accountable for their decisions and actions, making choices based upon objective evidence and professional judgement, and acting within the public interest to save life and preserve life.

10.2.2 In evidence PC Paton and PC Walker considered the terrorism possibility for this incident. Other staff have either discounted terrorism or not considered it relevant.

10.2.3 PC Paton stated in his oral evidence, that prior to his arrival at scene:

10.2.3.1 “We were needing to know then was an ARV coming or was it no?”

10.2.3.2 “Was an ARV coming or is it not. If it is, where's it coming from, ETA. Likewise with a dog, same information”

10.2.3.3 “As with every knife call, not just this one, as with every knife call I consider terrorism until I get further information to rule it in or rule it out.”

10.2.3.4 “if a weapon's mentioned then it's a case of "all units, if you can do, drop everything and go."

10.2.3.5 “without the attendance of an ARV or a dog, but more so an ARV, then somebody had to deal with it.”

10.2.3.6 “a knife is always dangerous”

10.2.3.7 “There was a strong rumour going about in Kirkcaldy Police Station that a female officer was going to get injured by a lone wolf.”

10.2.4 PC Craig Walker in his oral evidence stated:

10.2.4.1 “I heard a radio broadcast from Sergeant Maxwell requesting all units to attend this call. He then asked the control room about the availability of an ARV, which is an armed response vehicle with firearms officers, and also a dog vehicle. The control responded by saying there was no ARV and they would check for a dog vehicle but they thought the dog was through west. I think PC Paton acknowledged we were en route.”

10.2.4.2 “My recollection was that there was -- they would check for a dog unit and they were basically saying that they believe a dog unit is en route but that hadn't been confirmed, therefore -- there's a big difference between believing something is getting organised and they're actually coming, and as for the ARV, I think I would have been aware of that, that on a Sunday morning we wouldn't have had a local firearms unit.”

10.2.4.3 “I was aware that five separate calls had been received about the male and that a description of a large, muscular, black man wearing white T-shirt and black jeans had been passed. I'm also aware that the weapon he was carrying had been described as both a large knife and sword. It was also stated that the male

appeared to be under the influence of a substance and was attacking passing cars, running out into the street at the vehicles."

10.2.4.4 "I was very concerned about the nature of the incident and the number of calls being made by the public and the nature of the reports being made, being that he was attacking passing vehicles and he might be prepared to attack us when we arrived. PC Paton and I both considered the near to locus mental health hospital at Whytemans Brae and the main hospital, the Victoria Infirmary, and the fact that he may be a patient from either. Due to the overt nature of his actions, I also considered that he was doing this to get the police to attend to either target officers or to elicit a suicide-by-cop scenario."

10.2.4.5 "The only factors considered when assessing the risk were the words 'big', 'muscular' and 'carrying a knife'. Race did not play a part in my risk assessment."

10.2.4.6 "I was aware that this was a high risk situation and that the male's behaviour was drawing the attention of many witnesses. I was of the opinion that this was a serious incident and the male was posing a real risk to the public and himself. I was concerned for my own safety given the level of threat being described over the radio and the number of calls being received by the police."

10.2.4.7 "The fact that it had been passed as an ongoing disturbance, that there was a male in possession of a knife and the word "chasing" was used in the call that was passed over, and the fact that it was, like I say, quite an overt thing about -- normally when you get a call, it's like two people fighting and somebody might be in possession of a knife, but this gentleman is clearly chasing somebody, or it was passed as chasing somebody and was in possession of a 9-inch -- or I -- described as a large knife."

10.2.4.8 "You know this is credible members of the public, numerous credible members of the public all phoning in to report exactly the same thing."

10.2.4.9 "certainly in my mind it showed that he was not just carrying the weapon for intimidation, he was using the weapon, he had an intent to strike out, so yes that's certainly something."

10.2.4.10 "if they're using it to strike out at other things, then you have to go on the assumption that they're looking to harm other people, so yes, you have to take that into consideration before approaching them."

10.2.4.11 "Obviously knives are dangerous. You only need one wound and that could be fatal, so aye, you've got to be careful with knives."

10.2.4.12 "when you're travelling to it, you're just trying to put some context around about the call. This comes back to the decision-making model, just thinking about as much intelligence as you could get, what's round about, what we're likely to be dealing with, but ultimately you have just got to deal with what's presented with you when you get there."

10.2.5 Officers should be travelling and thinking about a variety of checklists which they are trained to use. This would include thinking about:

10.2.5.1 Are they suffering a mental health crisis and the need to look for information to confirm or refute this consideration.

10.2.5.2 Are they intoxicated with drink and/or drugs and the need to look for information to confirm or refute this consideration.

10.2.5.3 Are they medically ill and the need to look for information to confirm or refute this consideration.

10.2.5.4 Is there a knife? And could there be other weapons?

10.2.5.5 Is there a crime scene and forensic evidence to be considering?

10.2.5.6 Is this a stop and search procedure, a mental health detention, or a criminal arrest, or a combination?

10.2.6 Factors relevant to the assessment of risk to Mr Bayoh would include the considerations for tactical options. He may be intoxicated, experiencing a mental health crisis, or be experiencing a medical incident. As Mr Bayoh has not been identified to officers they may also approach the wrong person, as mistaken identity. PC Walker stated he had considered the subject may be from, or connected to, the mental health unit.

10.2.7 The officers also appear to be under the belief that neither an ARV or dog unit is available to assist, and that they are obligated to deal with the incident.

10.2.8 If the subject is intoxicated this may reduce the likelihood of successful communication and increase the potential for use of force. General patrol officers are limited to their equipment and physical skill. Use of force upon an intoxicated person increases the risk of serious harm/death to the person. They may require a medical assessment.

10.2.9 If the subject is experiencing a mental ill health crisis incident this may reduce the success with communication and increase the likelihood for use of force. Use of force upon a person in mental health crisis increases the risk of serious harm/death to the person. They require medical assistance and a tactic to contain and build rapport rather than restrain.

10.2.10 If the subject is experiencing a medical emergency the risk to them also increases if force is used. They require medical assistance.

10.2.11 Attending officers are not specialist officers and are not medically trained. The incident reported could be a crime, but could also be non-crime and healthcare focused. It would be essential for the attending officers to be mindful that this may be a vulnerable person in need of help, rather than a criminal justice case.

10.2.12 I have viewed the training records of PC Paton[75] and PC Walker[76]. PC Walker completed a three-day constable custody course in 2012 but I am unaware of the content of this course. There is no such course listed for PC Paton. Neither officer has any previous training for PSU public order, which would be involving ‘mutual aid’ training for use of shields and dealing with deranged and violent people. PC Walker had completed the three-day first aid at work course in May 2012 which is valid for 3 years. This is a course which I used to teach until 2021. He also completed a 1-day defibrillator course in 2013, again this is a course I used to teach until 2021.

[75] PS00055
[76] PS00061

10.2.13 Any incident involving a weapon poses a risk of injury to responding staff, even if the person is in need of medical attention. Officers must be mindful of the NDM and their training to stay safe. Both officers acknowledge in their evidence that they considered this incident to be high risk due to the multiple reports of the weapon.

10.2.14 Attending officers could make the decision to not engage with Mr Bayoh, and relay information to the ACR, from a safe distance, seeking further instruction. However, PC Walker stated that he was of the belief that ARV and dogs were not available. He could have checked this with the ACR.

10.2.15 Factors for the officers to take into consideration would include: reports of the knife size; potential for other weapons to be concealed; size of subject compared to them; perceived physical strength compared to them; considerations for intoxication, mental ill health or medical ill health; time of day; available back-up; availability of specialist resources; location risks such as the road and escape routes; vulnerable nearby locations such as the hospital sites.

10.2.16 Risks to the public would include to the public's health and wellbeing if the subject uses the weapon against any member of the public. Upon arrival no member of the public was physically present. They could have arrived at the scene, but at the time the immediate danger was not present. If officers caused the subject to disperse this could cause him to run towards members of the public and increase the risk to the public. The knife was not visible upon arrival, and if the officers approach the subject this could result in the knife being produced. If a subject panics, it increases the risk of them spontaneously attempting to avoid police interaction/capture. This can increase the risk for hostage taking. This emphasises why a commander is required for high-risk incidents as they receive greater training for spontaneous decision-making, and should be far more aware of possible outcomes and best practice tactical plans.

10.2.17 I believe that a reasonable officer would conclude that two lone, unarmed, officers arriving at the scene of a man with a large knife would be encountering a high-risk incident for the subject, themselves and the public. The reason being that they will be unable to

contain a person in an open environment, if the subject decides to take off. This may displace the risk to a more vulnerable location.

10.2.18 Two officers are unlikely to be successful in the containing or detaining of such a subject. This is a high-risk incident, and in my opinion, two unarmed officers should not be approaching or attempting to detain the person.

10.2.19 From the moment officers arrive, they are trained to begin looking for warning signs and behaviours that a person may trigger such as for mental ill health, intoxication, medical emergency, or criminal intent.

10.2.20 Concerning the ACR staff, they knew they were sending unarmed officers sporadically to the scene of a potentially armed man. They knew this was an unusual incident and had made enquiries concerning the location of ARV and dog units. They knew that several independent reports stated the subject was armed with a large knife. They knew the man was walking along the public highway. This would indicate significant risk to attending officers, members of the public and the subject themselves.

10.3 What conclusion would a reasonable officer have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
Why?

10.3.1 A reasonable officer arriving would see a man who is under dressed for the weather with bulging eyes. Officers should be immediately thinking about mental, physical and intoxication risks. Containment is the preference for any person showing these signs until additional risk factors can be considered. An ambulance attendance should be a consideration at this point.

10.3.2 Officers should be considering risks to themselves based upon these factors and the size of the subject and possibility of a knife. Maintaining distance would be the priority and attempting to build rapport with the subject.

10.3.3 Currently there is no member of the public immediately available for immediate risk. Officers will not want to disperse the subject and should be aiming to contain them. A containment is unlikely with only two officers.

10.4 How would that risk assessment inform the available tactical options

10.4.1 The reasonable officer should perform their own dynamic risk assessment. This includes taking into consideration all information provided by the ACR staff. It is reasonable to believe that the ACR staff have conducted the first risk assessment to come to the decision to deploy the unarmed officers. The NDM process should be conducted en route with what information they have to consider - policy, powers and options. Upon first sight of Mr Bayoh and before they stop the van, he is not attacking any member of the public, and no knife is visible. The necessity to immediately stop and act is reduced. Two officers are unlikely to be successful with a containment, and may cause the subject to flee the scene. Tactical options would include:

10.4.1.1 Drive by and update ACR whilst awaiting a tactical plan;

10.4.1.2 Stop the van, remain in it, and see if the subject will speak to officers;

10.4.1.3 Stop the van and exit the van to engage with the subject for a stop and search procedure.

10.4.2 The officers reported that Mr Bayoh's immediate sighting caused them some concern. This indicated another unusual factor with this incident. The officers could make the decision to drive by, keep their distance, observe, feeding back information to ACR, and awaiting additional resources and a renewed tactical plan.

10.4.3 In my opinion the reasonable officer response at this time would be to drive by and wait for additional resources; update ACR with all visible information concerning the subject and confirm if specialist resources were available.

11 Question 2B. First officers at locus: Constables Walker and Paton

- **11.2 In light of the information known to Constables Walker and Paton (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **11.3 What conclusion would a reasonable officer, arriving first at the scene, have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **Why?**
- **11.4 How would that risk assessment inform the available tactical options?**

11.1 General Information

11.1.1 All officers are expected to use the NDM as part of their decision-making process. PC Walker and PC Paton knew that numerous reports had been made concerning a large male with a large knife. Upon their arrival they see a man, Mr Bayoh, who they believe is the subject. He fits the description provided, except he does not have a knife visible. Mr Bayoh has not been identified by any person so there is also the possibility of mistaken identity to consider, but there are sufficient grounds to stop and search.

11.1.2 PC Walker and PC Paton must use their training and knowledge to make a decision, and remain flexible with their decision-making, based upon the NDM. They still have the option to not engage with Mr Bayoh, and continue by reporting back to the ACR for guidance from the ACR Inspector, as no knife is visible. Officers should consider the following questions/points, as part of the NDM process, which the ACR staff should also have considered as part of the NDM process:

11.1.2.1 What is happening?

11.1.2.2 What do I know so far?

11.1.2.3 What do I not know?

11.1.2.4 What further information (or intelligence) do I want/need at this moment?

11.1.2.5 Do I need to take action immediately?

11.1.2.6 Do I need to seek more information?

11.1.2.7 What could go wrong (and what could go well)?

11.1.2.8 What is causing the situation?

11.1.2.9 How probable is the risk of harm?

11.1.2.10 How serious would it be?

11.1.2.11 Is that level of risk acceptable?

11.1.2.12 Is this a situation for the police alone to deal with?

11.1.2.13 Am I the appropriate person to deal with this?

11.1.2.14 What am I trying to achieve?

11.1.2.15 Will my action resolve the situation?

11.1.2.16 What police powers might be required?

11.1.2.17 Is there any national guidance covering this type of situation?

11.1.2.18 Do any local organisational policies or guidelines apply?

11.1.2.19 What legislation might apply?

11.1.2.20 Is there any research evidence?

11.1.2.21 The options that are open.

11.1.2.22 The immediacy of any threat.

11.1.2.23 The limits of information to hand.

11.1.2.24 The amount of time available.

11.1.2.25 The available resources and support.

11.1.2.26 Their own knowledge, experience and skills.

11.1.2.27 The impact of potential action on the situation and the public.

11.1.2.28 What action to take if things do not happen as anticipated.

11.1.3 The Police Scotland NDM powerpoint presentation[77] which has been disclosed to me states that: “An example of a working strategy:

- Maximise the safety of any victims.
- Maximise the safety to the public in the immediate area.

[77] PS13182 [redacted]

- Minimise the risk to any unarmed police/staff.
- Minimise the risk to any specialist officers.
- Maximise the safety of the subject(s).
- Arrest subjects.
- Recover and preserve any evidence/weapons".

This would be applicable to the officers attending the scene and the ACR staff who deployed them.

11.1.4 The Police Scotland NDM powerpoint presentation gives examples of options at an incident:

- Wait
- Take Mitigating Action
- Keep The Subject Under Observation
- Carry Out an Investigative Assessment
- Contain the Area Around the Subject, Thereby Minimising the Opportunity for Harm
- Communicate with the Subject
- Take Decisive Action.

11.1.5 The Police Scotland Officer Safety Training (OST) powerpoint presentation is dated July 2013 and includes information for the '5 step positive style of tactical communications' and includes:

1. Ethical appeal
2. Reasonable appeal and explain
3. Personal appeal and options
4. Practical appeal and confirmation
5. Action

11.1.6 For gaining compliance the powerpoint presentation states:

- Communicate
- Explain
- Ask
- Inform
- De-escalate

11.1.7 The threat assessment slide covers the three areas:

- Person
- Object
- Place

11.1.8 Concerning jeopardy, the powerpoint states: “The principle of jeopardy relates to the following 4 elements combining to provide a distinct threat of harm to the officer or others, including the subject themselves:

- Opportunity
- Means
- Ability
- Intent”

11.1.9 Impact factors are listed as being: size, age, gender, strength, intoxication, numbers, jeopardy (opportunity/means/ability/intent), weapons, specialist skills, injury, fitness, exhaustion, specialist knowledge, nature of crime, proximity of others, domestic situations, escape routes, weather, conditions underfoot, officer perception.

11.1.10 The conflict resolution model is displayed on slide 17 showing profiled offender behaviour, impact factors and officer response options.

11.1.11 Profiled offender behaviour is listed as being:

- Level 1 - Compliance
- Level 2 - Verbal Abuse and/or Gestures
- Level 3 - Passive Resistance

- Level 4 - Active Resistance
- Level 5 - Assaultive Resistance
- Level 6 - Serious or Aggravated Resistance

11.1.12 Officer response options are listed as:

- Level 1 - Officer Presence
- Level 2 - Tactical Communication
- Level 3 - Control Skills
- Level 4 - Defensive Tactics
- Level 5 - Deadly Force

11.1.13 Slide 21 lists options for officers as being:

- Create space
- Use loud positive verbal commands
- Establishing a defensive stance
- Move outside fighting arc
- Draw Baton/CS/Use appropriate tactical communications

11.1.14 Slide 22 covers edged weapons and states:

- Create distance
- Use cover
- Transmit

11.1.15 Factors relevant to the risk assessment for PC Walker and PC Paton will include:

11.1.15.1 Impact factors – Person: would include large and muscular looking, male, perceived to be strong, perceived to be intoxicated and/or mentally unwell, young, able bodied, potentially in possession of a knife or other weapon, perceived intent to cause harm/injury/damage. Object: the perceived knife which they may have concealed on their person or have ready access to. Place: would include uncontrolled public place within a community setting, multiple escape routes,

weather conditions, road and moving traffic, lack of specialist officer knowledge, lack of specialist officers attendance/presence, and proximity of nearby hospitals.

11.1.15.2 Profiled offender behaviour – Information received is that the subject they are looking for has been 'chasing' vehicles. The officers seeing Mr Bayoh see a man fitting the description but there is no knife visible and he is not being disorderly.

11.1.15.3 Officer response options – Officers do not have specialist officer skills or tactics available to them such as a police dog, Taser or shields.

11.1.16 The tactical options would include for the officers to consider the necessity to engage with Mr Bayoh in the first instance. They should have received clear and unambiguous direction from the ACR concerning their deployment and the stay safe direction. They should have updated Control upon their arrival to seek further direction, but they are also required to dynamically assess the risk and necessity to engage. The basic principle for a potentially armed subject is for patrol officers not to engage with them.

11.1.17 For the attending officers, a reasonable officer would be mindful that the risk to themselves would include being stabbed if they enter the personal space of a person who may be armed with a knife. The safest tactical option for the officers would be to remain in their vehicle. If deemed necessary to attempt to engage with Mr Bayoh, to do so through the van window.

11.1.18 A reasonable officer would, if engaging with Mr Bayoh, attempt to confirm that he is the person in question and whether or not he is in possession of a weapon. A reasonable officer would attempt to maintain a distance between them and him, to provide a reactionary gap, at the minimum, as there was not currently an immediate threat to a member of the public.

11.1.19 Concerning the initial interaction with Mr Bayoh, PC Paton stated in oral evidence[78] that Mr Bayoh's "eyes were bulging out of his head" upon their arrival. This

[78] Line 25 page 30. Day 20 transcript.

could indicate a medical emergency, through intoxication and/or mental health crisis, and should be taken into consideration within the initial risk assessment. This information should have been relayed to ACR and a request for medical assistance to be considered by the ACR.

11.1.20 Officers still have a tactical option to retreat, move away, and deploy to an RV point. I am of the opinion this would increase a reasonable officer's opinion that they were dealing with a medical or mental health crisis and would drive by to update ACR and await instruction. Likewise, ACR could direct officers to 'abort' and leave the scene.

11.1.21 Mr Bayoh had not been identified as having committed a crime of violence against a person, and the incident could still be one of him requiring help, being a vulnerable person in need of care under the Mental Health Act, or requiring medical attention. Officers must conduct a threat assessment upon their arrival and consider the required tactical response.

11.1.22 With no exhibited violence or weapon, the reasonable officer response as per officer training, if they were to engage, would indicate tactical communications as a suitable response option. A simple question such as "Can we speak to you a moment?" to establish the subject's response could have been asked. The subject may be in close proximity to a weapon, therefore officers should maintain a safe position such as remain in the vehicle and/or maintain a reactionary gap.

11.1.23 To engage in any physical force against Mr Bayoh increases risk of harm to him, if he is intoxicated and/or in mental health crisis; and at this point his identity is not confirmed. It could still be a case of mistaken identity. The reasonable officer would be mindful that the risk to the public still exists, if a man is in the community armed with a knife.

11.1.24 When the officers did attempt to communicate with Mr Bayoh he was described as, at most, exhibiting level 2 of the profiled offender behaviour – exhibiting body language which indicated non-compliance. The reasonable officer response to a level 2 behaviour is taught as still including the use of tactical communications. Level 2 profiled offender

behaviour is described in the Use of Force SOP[79] as being “verbal resistance and/or gestures. This includes shouting, swearing and verbal challenges to requests and/or instructions given. It normally includes non-verbal gestures and posturing (body language) and can consist of warning and danger signs of potential attack.” The lower level, level 1, states: “Compliance. Most people dealt with are reasonable and will comply with any lawful instruction. The compliance may be verbal or it may be active compliance such as stopping an action when told.” In my opinion Mr Bayoh, at most, is a level 2. Section 4 of the OST Manual states that “Compliance has both verbal and body language components which are easy enough to identify. Open hand gestures with the palms facing the officer are the most common physical signs.” PC Paton described in his oral evidence that upon initial encounter Mr Bayoh had “Palms of his hands like that (indicates).” [80]And demonstrated an open hand gesture.

11.1.25 A factor to consider is that Mr Bayoh’s lack of engagement was not described as an act of aggression. He attempted to walk on by. PC Paton stated that he first noticed Mr Bayoh’s eyes bulging “When I first saw him”. He also stated: “quite often on a lot of these synthetic drugs you don't feel temperature, not how you should, and it was pissing down with rain and blowing a gale, and he's wearing a wee T-shirt”. This indicates that upon arrival PC Paton immediately formed an opinion that Mr Bayoh may be intoxicated with drugs. Police Scotland included in their OST powerpoint presentation that intoxication with drink or drugs increases the risk of positional asphyxia. Slide 26 of the OST powerpoint covers the topic of excited delirium and states: “A person exhibits violent behaviour in a bizarre and manic way; Constant, purposeless, often violent activity; Meaningless speech and hallucinations with paranoid delusions; Abnormal strength and pain tolerance; CS may not work.” At this point PC Paton has described bizarre behaviour, signs of intoxication with bulging eyes, knowledge of purposeless and violent behaviour of lashing out at vehicles, and inappropriate clothing for the weather. The reasonable officer should be considering everything they see and hear to compare to their mental

[79] PS10933
[80] Line 1 page 32, Transcript day 20.

checklists of conditions to consider or refute. Deaths in custody is a significant topic taught within police training for officers to consider from the point of initial contact, and they must be alert to behaviours or warning signs being exhibited from subjects.

11.1.26 The presentation covers causes of excited delirium as being:

11.1.26.1 Drug and/or alcohol intoxication;

11.1.26.2 Psychiatric illness; or

11.1.26.3 A combination of the above.

11.1.27 The presentation continues concerning excited delirium and stated for medical emergency:

11.1.27.1 Expect a sudden collapse.

11.1.27.2 Acute exhaustive mania can be fatal.

11.1.28 This would be significant information to update ACR with. Officers should be thinking about excited delirium and/or a severe mental health crisis. At this point medical attention should be a vital consideration and an ambulance requested via ACR. If Mr Bayoh is to be arrested it is essential that these facts are taken into consideration and that custody unit staff are informed. If a detainee is taken to a police custody unit suspected of suffering from any form of mania, they are unlikely to be accepted at custody. The reasonable Custody Sergeant will divert the detainee to a hospital, unless they are too violent, in which case an ambulance and the police healthcare professional will be called. In light of this it is my opinion that a reasonable officer would be thinking mania and mental health crisis and instigate the ambulance request from the point of initial encounter. Suitable medical assistance must be provided at the earliest opportunity and medical attention takes priority over apprehension.[81]

[81] Care and Welfare of Persons in Police Custody Section 5.3

11.1.29 The risk assessment process commences from the initial contact and the officer has a responsibility to impart all information they gain during their interaction[82]. Officers are taught as part of the OST training to consider these conditions from initial encounter.

11.1.30 PC Paton agreed in his evidence that he had considered that Mr Bayoh may be a patient from the nearby hospital. This would be a reasonable line of enquiry for the ACR staff to follow up, at the request of the attending officers, and call the hospitals to establish if any person was missing. ACR staff have the capacity to conduct enquiries on behalf of officers attending incidents. PC Paton should have shared his concern with the ACR who should have then made enquiries with the nearby hospitals to establish any missing patients. The ACR Inspector has access to numerous resources in order to conduct enquiries.

11.1.31 The Police Scotland OST manual covers excited delirium at Module 1 section 11. Details can be found at section 8 of my report.

11.1.32 Police officers are not medically trained, and not all are fully first aid trained to the civilian equivalent of a three-day first aid at work course. College of Policing custody first aid training is recommended as the content of the three-day first aid at work course plus additional custody specific topics which includes acute behaviour disturbance/excited delirium. PC Paton had not completed a basic first aid at work course, completing only the basic emergency life support training as part of the OST programme. With his level of training he had recognised that Mr Bayoh may be experiencing a drug induced condition. This alone should have triggered consideration of a medical risk being present which ACR should be informed of.

11.1.33 PC Walker had completed a three-day first aid at work course. This does not make him a medical professional, but it meets the Health and Safety Executive's requirement to be classed as a first aider in the workplace. A standard first aid at work course does not include any input concerning excited delirium. He had completed a three

[82] Care and Welfare of Persons in Police Custody Section 8.1

day Constable custody training course, but I am currently unaware if the subject matter was included on that course.

11.1.34 Overall, both PC Paton and PC Walker clearly recognised that Mr Bayoh may be under the influence of some form of intoxication and/or mental health crisis. This should have formed part of their risk assessment process, for a rapid review of the NDM for policies/powers and options/contingencies. This would require the officers to consider their communication style and risks to them, Mr Bayoh and the public. Officers are taught that "the majority of the message is NON-VERBAL. It is, therefore, vitally important that officers learn to use appropriate body language which concurs with what they are saying."[83]

11.1.35 A person in mental health crisis or intoxicated can be unpredictable in behaviour, and also frightened. By maintaining a distance and using calm words and body language, an officer may be able to establish a rapport with the person. If a person is under the influence of drink or drugs they may not be acting rationally, so may not respond just to the officer's physical presence and it may be necessary for the officer to change their interaction, speed, tone and level of their voice. A basic principle for dealing with a person experiencing a mental health crisis would include approaching the person calmly with a low consistent voice and asking them if they need help. Their response will then feed back into the NDM.

11.1.36 PC Paton was in possession of CS. I have been trained to use CS and have been involved in incidents where CS has been deployed, although I do not recall discharging my CS. The use of CS can, sometimes, incapacitate officers at the incident, more than a suspect, and suspects attending police custody contaminated with CS can contaminate the custody unit. Officers are taught that CS/PAVA may not work on a person who is suffering a mental health crisis or who is intoxicated. The Police Scotland OST manual at Module 7 states:

---

[83] OST Manual Module 1, Section 4

11.1.36.1 "CS sprays should generally be used at distances of between 1 and 2 metres (3ft – 6ft) from the subject. At distances closer than 1 metre (3ft) there is a possibility that the stream of CS solution could exert sufficient 'hydraulic pressure' to damage the eye. At distances greater than 2 metres (6ft) accuracy is lost and the spray is less effective, particularly in windy weather conditions."[84]

11.1.36.2 "The spray is primarily intended for use against one individual and the canister is designed to deliver approximately 6 seconds worth of spray."[85]

11.1.36.3 "Incapacitant spray failures have been noted on three categories of subject:

- People with serious mental disorders
- People under the influence of drink or drugs
- People with a positive mental mind set/goal."[86]

11.1.36.4 "Officers should not rely on incapacitant sprays to the exclusion of other officer response options. Subjects may become more aggressive following the use of an incapacitant spray."[87]

11.1.36.5 "Incapacitant sprays are not a replacement for other use of force options, they are an addition. Only the individual officer can decide when to utilise the spray."[88]

11.1.36.6 "All persons arrested or detained who have been sprayed with CS will be regarded as special risk prisoners."[89]

11.1.37 The use of CS/PAVA is a use of force. The Police Scotland OST manual explains the 'assault cycle' which is often referred to as 'Betaris box'. This explains how your attitude affects your behaviour which in turn affects the other person's attitude and behaviour. CS/PAVA spray is classed as an officer response option at level 4 – defensive tactic. The OST manual states: "Defensive tactics include the use of CS Spray, Batons,

[84] OST Manual Module 7 Section 2 Page 161
[85] OST Manual Module 7 Section 2 Page 162
[86] OST Manual Module 7 Section 2 Page 162
[87] OST Manual Module 7 Section 2 Page 162
[88] OST Manual Module 7 Section 2 Page 162
[89] OST Manual Module 7 Section 2 Page 166

Empty Hand Techniques, Handcuffs, Taser and Baton Guns". Defensive tactics are taught as an officer response to an offender profiled behaviour at level 5 - assaultive resistance, and level 6 – serious aggravated resistance. On the basis of the presenting behaviours from Mr Bayoh, the use of CS and/or PAVA was likely to be ineffective and not consistent with the presented level of visible threat.

11.2 In light of the information known to Constables Walker and Paton (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?

11.2.1 In summary, PC Walker and PC Paton knew that Mr Bayoh had allegedly been behaving bizarrely, lashing out at passing traffic with a knife, was dressed inappropriately and upon seeing him had bulging eyes. They believed he was intoxicated with a substance. There were sufficient grounds for the officers to believe that Mr Bayoh was suffering some form of intoxication and/or mental ill-heath crisis. This was sufficient to identify he needed medical attention.

11.3 What conclusion would a reasonable officer, arriving first at the scene, have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
Why?

11.3.1 Risks to the officers included the knife as this had not been refuted and could be used against them. Mr Bayoh needed medical attention and a delay of the medical attention could create risk to his health and wellbeing. Although a risk existed to the hypothetical member of the public, there was no immediate member at risk.

11.4 How would that risk assessment inform the available tactical options?

11.4.1 Officers are trained to contain rather than restrain a person who is suffering from any form of mania, which would include excited delirium. An intoxicated person suffering

from any form of manic behaviour can increase risk to officers, themselves and the public. Containing Mr Bayoh would be a priority and seeking to not escalate his manic behaviour by building rapport. Requesting an ambulance would be a priority.

12 Question 2C Second officers at locus: Constables Tomlinson and Short

- **12.2 In light of the information known to Constables Tomlinson and Short (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **12.3 What conclusion would a reasonable officer, arriving second at the scene; have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?**
- **Why?**
- **12.4 How would that risk assessment inform the available tactical options?**

12.1 General Information

12.1.1 Constables Tomlinson and Short arrived at the scene aware of the same risk factors which Constables Paton and Walker were informed of, i.e. reports of a large male with a large knife. Impact factors would include size, age, perceived strength, sex, intoxication. They would also be required to use the NDM and base their tactical response options upon the threat and risk presented.

12.1.2 PC Short stated in her evidence that upon their arrival at the scene she witnessed PC Paton and PC Walker standing with Mr Bayoh, in a triangle formulation. She did not see a knife and Mr Bayoh had his fists clenched as he moved towards the officers. She states his fists were clenched, and PC Paton stated Mr Bayoh's hands were open palm.

12.1.3 A reasonable officer response would be prior to exiting their vehicle, updating ACR with what they could see to enable a review of deployment tactics and patrols. They arrived at the scene at 07:20:30, which is approximately 7 seconds after PC Walker and PC Paton, and 12 seconds prior to PC Paton activating his emergency button. Inspector Stewart's message to attending patrols finished at 07:20:29.

12.1.4 PC Tomlinson, was still a probationary officer at the time of the incident and had approximately 18 months service. He stated in his evidence:

12.1.4.1 PIRC[90] statement: “I approached the roundabout at about 50 mph and drove over the roundabout. I turned the vehicle into Hayfield Road and saw the 19 van parked nose into the bus stop on the left hand side. I then saw a black guy on the pathway which cuts the corner between Hayfield Road and Hendry Road, same side as bus stop. I saw this male walking directly at Craig Walker at the passenger side of his van face to face. I didn't see Alan Paton.”

12.1.4.2 PIRC statement: “I saw Craig lift his hands to his face and my first thoughts were that he had been slashed because of the mention of a knife on airwave. As soon as Craig held his face, the black guy turned away and did a bouncy type of walk which was almost like he had won a victory or something. He strutted along the pathway. I shouted "desist" and he turned round to look at me with a kind of dirty look. I shouted for him to stop and I didn't know whether he had a knife or not. I followed him to the path at the shrubbery. I was parallel with him.”

12.1.4.3 PIRC statement: “I got my CS Spray out but I could not see a knife. I thought Craig had been slashed. The black man did not say anything and his fists were clenched. I sprayed my CS at him from about 4 or 5 metres away from him.”

12.1.4.4 Evidence in chief[91]: “A knife is in effect a deadly weapon, so to have more units there would allow us to maybe look at different options and use different tactics, which I will come on to later on, but things like, for example, containment and things like that, without going in that situation with a kind of pre-judgment, it was just to give us the best kind of tactical options and to go in there with, kind of, almost everything really available to us.”

12.1.4.5 Evidence in chief[92]: “there's a range of different options you could use. You could simply drive up and park and monitor, you could try a containment.”

---

[90] PIRC-00263
[91] Line 14 Page 12 Transcript Day 9
[92] Line 4 Page 13 Transcript Day 9

12.1.4.6 Evidence in chief[93]: “if you turned up and, you know, the person's got a knife, you probably wouldn't get out of the car, you would relay that message back to the control room, so you could effectively observe from your vehicle.”

12.1.4.7 Evidence in chief[94]: “I know Hayfield Road's quite a busy road. I know it's Sunday morning, but certainly at that time in the morning you've got like the hospital is quite a large employer in the area so you've got the passing traffic and shift changeover, so that's probably one of the things I would have considered but I knew that area was also quite well built-up as well and you've got a variety of houses and footpaths, so they would have been the things that I would consider kind of going to the locus.”

12.1.4.8 Evidence in chief[95]: “I have mentioned here a lack of resources for any meaningful containment, so again, if a person is going to break free and maybe charge at you or get close to you, you know, you're putting yourself within danger of striking distance from a bladed article.”

12.1.4.9 Evidence in chief[96]: “I would want to avoid getting anywhere within a fighting arc of a person who may or may not have a knife if it has been deemed by, you know, the controller as a knife incident because we've got members of the public phoning in, I wouldn't be complacent about that, I would treat the situation as if a knife is potentially present until I can secure the individual or locate the knife.”

12.1.4.10 Evidence in chief[97]: “What was also probably going through my head as well is it might not have been reported yet but there may be a casualty there as well and again that would be a risk to a member of the public that we have maybe just not had that report yet that because nobody is physically aware that somebody has maybe been injured. It's obviously described as a disturbance, so a disturbance normally would indicate there's some sort of contact with people, especially if you're getting

---

[93] Line 5 Page 14 Transcript Day 9

[94] Line 7 Page 27 Transcript Day 9
[95] Line 11 Page 33 Transcript Day 9
[96] Line 17 Page 33 Transcript Day 9
[97] Line 1 Page 36 Transcript Day 9

numerous calls, and the need to contain the person obviously. We're in a residential area so you've got people in their houses that might leave their doors unlocked and things like that, so you've got all these things -- well, all the things going through my head about the dangers to members of the public, and obviously a member of the public doesn't have the luxury of a stab vest."

12.1.4.11 Evidence in chief[98]: When asked was he considering the risk to Mr Bayoh the officer replied "I was, yes" and followed up with: "So the risk to Mr Bayoh is obviously the risk of self-harm. We don't know why the police have been called, we don't know what this disturbance is. He could already be injured. He could be in possession of a knife. He could be throwing himself in front of vehicles or, you know, under the control -- sorry, not under the control -- under the influence of a substance so obviously that impacts his safety and his welfare so that's obviously one of my concerns as well. Officers trying to safely restrain Mr Bayoh, that could cause, you know, injuries as well from being taken to the floor, so these are all things that I would be considering when I was going there."

12.1.4.12 Evidence in chief[99]: "Just the proximity to the hospital, the kind of almost erratic behaviour. You would probably naturally consider that as a potential risk as well."

12.1.4.13 Evidence in chief[100]: "with two people you can use contact and cover, which is something that's taught in officer safety training, and by that what I mean is contact, one officer would try and open up lines of communication with the individual and the cover officer would be there to monitor from a little bit kind of more of a triangular position, so you've got the individual, one officer for contact, one officer for cover."

12.1.4.14 Evidence in chief[101]: "contact would be like trying to speak and use your communication skills to get an understanding of what's going on."

---

[98] Line 21 Page 37 Transcript Day 9
[99] Line 20 Page 38 Transcript Day 9
[100] Line 14 Page 39 Transcript Day 9
[101] Line 6 Page 40 Transcript Day 9

12.1.4.15 Evidence in chief: “Certainly I would take each individual incident on its own merits and I wouldn't go in with a pre-judgment of how this is going to play out, so as much as I've got my experience, I wouldn't say I rested on that experience.”

12.1.4.16 Evidence in chief[102]: when asked “Do you have a recollection now of how, if at all, this differed from previous knife incidents that you had attended?” he replied “The volume of calls coming in”

12.1.4.17 Evidence in chief[103]: “When I got out of my van and the first thing I seen -- seen him do was that (indicating), so he put his hands to his face”. PC Tomlinson was indicating what he believed to be PC Walker having been slashed in the face by Mr Bayoh.

12.1.4.18 Evidence in chief[104]: “so my initial thought, given the number of the calls in relation to a knife was that PC Walker had been slashed to the face, or injured to the face, hence the reason he has put his hands up.”

12.1.4.19 Evidence in chief[105]: “Mr Bayoh started to then walk away from PC Walker and I started to shout like "Get down", like "Stop what you're doing."

12.1.5 PC Tomlinson stated he believed, upon their arrival, that PC Walker may have been slashed to the face with a knife. This fact, if true, would indicate a level 6 - aggravated/assaultive offender profile behaviour. Believing a colleague had been slashed with a knife would be important information to pass to ACR seeking urgent medical attendance and specialist police response. Preservation of life is the priority and a reasonable officer would attempt to confirm if officers had been slashed, and if safe to do so, render immediate first aid until medical assistance arrived.

12.1.6 As Mr Bayoh was moving away from PC Walker it would be reasonable to shout over to PC Walker to see if he was okay, or visually run over to him to check if he had been stabbed. If PC Walker had been stabbed there would be blood rapidly visible and

[102] Line 12 Page 49 Transcript Day 9
[103] Line 9 Page 59 Transcript Day 9
[104] Line 16 Page 59 Transcript Day 9
[105] Line 16 Page 62 Transcript Day 9

emergency medical attention would be required. The risk to unarmed officers would be too high to continue to attempt to detain Mr Bayoh and a reasonable officer response would be to consider allowing Mr Bayoh to flee the scene, render emergency first aid to colleagues, whilst updating control for ambulance, ARV and dog(s).

12.1.7 If PC Tomlinson believed PC Walker had been stabbed, and he was not aware of where PC Paton was, the priority is preservation of life. If he called to the ACR that an officer “was down” having been stabbed/slashed, a reasonable FIM would direct for all officers to withdraw from the engagement to a place of safety, and formally declare the incident as a firearms incident. This would confirm that ARVs and dog units were the required response as the subject had demonstrated means and intent to stab a police officer(s). This would mandate certain tactical response principles. A primary principle being that unarmed officers do not engage with an armed subject. A reasonable ITFC will not deploy unarmed officers to confront an armed violent person without significant control measures. They would be required to justify any deployment of officers to such a risk. As referenced in section 8.3 of the Armed Response Operations SOP: “Police officers must not be expected to endanger their own lives or the lives of their colleagues in ill-considered attempts at rescue or to effect an early arrest”.

12.1.8 No member of the public was currently present and in immediate danger. The hypothetical person could have come along, but an officer should not risk their life for a hypothetical risk, unless that risk is likely to be realised. Operational guidance is clear throughout the UK that an unarmed officer, without Taser or firearm, should not engage with an armed subject. An officer would not be disciplined for retreating from an armed person they believed had stabbed or slashed their colleague to attempt to render lifesaving first aid to their colleague. If an officer could see a group of children approaching the subject then it is likely the reasonable unarmed officer will risk their life to save the children.

12.1.9 Had PC Tomlinson immediately went to the aid of PC Walker he would have established that he had not been stabbed and there was no necessity to withdraw for that reasoning. He may also have seen PC Paton and established the reason for him not

being present. Establishing that both officers were under the influence of incapacitant spray would inform PC Tomlinson's assessment of threat and risk.

12.1.10 The reasonable officer then knowing that 2 canisters of spray have been discharged and the officers are incapacitated through the spray, should then be aware of Mr Bayoh not being affected by such spray which increases the risk factors for excited delirium being recognised as a possibility, and ACR being notified for an ambulance attendance.

12.1.11 An officer is entitled to leave the scene of an incident if they consider the risk to them is too high, which was later demonstrated by PC Short when she attempted to run away from Mr Bayoh.

12.1.12 An officer must consider all risk factors and tactical options, which includes their skill level. A tactical option still remained to let Mr Bayoh walk away, being followed by officers who are updating ACR of the location for sending additional patrols.

12.1.13 PC Tomlinson and PC Short would have the option to establish their tactical plan. PC Tomlinson believed that PC Walker had been slashed, and could not see where PC Paton was. PC Short believed that CS/PAVA had been deployed and no stabbing had occurred. PC Short and PC Tomlinson were now the officers available to deploy a tactical plan, which would require rapid consideration of options and contingencies, working as a team. They needed to exchange information between them and ACR.

12.1.14 Having been present at incidents where CS has been deployed, I am aware that a smell is present in the vicinity. Due to the weather at the time this may not have been present for PC Tomlinson to be aware of.

12.1.15 PC Nicole Short stated in her oral evidence that:

> **12.1.15.1** "I just honestly felt like it was -- I just thought "It's just us, it's just us that have got to face this", and then obviously the more and more calls that came in kind of solidified in my mind that we were -- you know, that there was a male running about with a knife."

12.1.15.2 “I felt with the number of calls coming in thick and fast, the public were clearly scared and wanting -- wanting us to attend to protect them and make the area safe again. I just remember the urgency to get there so that nobody would be hurt.”

12.1.15.3 “I just remember the -- well, the controller saying "That's another call coming in, that's another one, that's another one", and normally you would get a call and you would have details passed and then you would attend and see what is presented to you when you're there, but the fact that it was just several independent members of the public made me think this is kind of in progress, if you like, and I had no reason to doubt that due to the volume, the numbers coming in quickly.”

12.1.15.4 “there had already been a request for an armed response unit and a dog unit to attend, so that was kind of as far as we could go at that point, but, like I said, nothing was confirmed, there was no definite confirmation of them definitely attending.”

12.1.15.5 “I could see Alan and Craig standing, and Mr Bayoh was kind of like -- he was in front of them, so it kind of formed a triangle-type thing.”

12.1.15.6 “and then Mr Bayoh was in front of them, so they were both facing him.”

12.1.15.7 “when I got out of the van and they had their sprays drawn.”

12.1.15.8 **“**I just remember approaching, seeing them both out of the van, initially they had their hands on their spray,”

12.1.15.9 **“**He was standing in front of them and when he was given these commands, there was just nothing. There was just no verbal response whatsoever and then he started to walk towards them.”

12.1.15.10 **“**I arrived and saw PCs Walker and Paton who were confronting Mr Bayoh at the path at the bus stop with their spray in their hands and shouting verbal instructions to him. They said 'Stay where you are, CS spray, PAVA spray, stay where you are.' They were both shouting at the same time.”

12.1.15.11 **"**Mr Bayoh was standing with his arms by his sides, fists clenched and then he moved towards them. That's when they both sprayed him. Mr Bayoh then walked away it to his right, up a path laughing and wiping the spray away from his eyes like it was water, like it had no effect on him at all. Bayoh was cold, almost blank, unresponsive, in a world of his own, disconnected, pumped up. He was on a mission whilst walking up the path."

12.1.15.12 **"**They shouted at him more to, you know, "Stay where you are, stay where you are", and then they sprayed him because it wasn't -- he wasn't listening."

12.1.16 PC Tomlinson and PC Short provide different accounts of the first arrival, and what they were confronted with. PC Tomlinson stated that upon arrival he believed PC Walker was slashed, which would mean the CS and PAVA had already been deployed. PC Short stated that CS and PAVA were deployed after their arrival, and after exiting the police vehicle.

12.1.17 PC Tomlinson and PC Short arrived approximately 7 seconds after PC Walker and PC Paton. PC Paton activated his emergency button at 07:20:42, which was 12 seconds after the arrival of PC Tomlinson and PC Short, and that his button was pressed after CS and PAVA had been deployed. In total this is approximately 19 seconds between their arrival and activation of the emergency button. A full CS canister has approximately 6 seconds of usage.

12.1.18 Factors relevant for PC Short and PC Tomlinson would include:

12.1.18.1 Their capabilities and experience;

12.1.18.2 The personal issues connected to Mr Bayoh such as his size, gender, age, perceived strength and perception of intoxication and/or mental health crisis;

12.1.18.3 The suspicion that there may be a knife, or other weapon(s) involved;

12.1.18.4 The location specific issues such as by a road, escape routes, members of the public being able to approach the area, proximity to hospitals, weather conditions and ground underfoot;

12.1.18.5 For PC Tomlinson that he believed PC Walker had been slashed with a knife;

12.1.18.6 For PC Short that she was aware CS/PAVA had been used without effect;

12.1.18.7 Lack of confirmed specialist resources attending.

12.2 In light of the information known to Constables Tomlinson and Short (as above, together with Mr Bayoh's behaviour/demeanour at the locus, and the absence of a visible knife), what factors were relevant to the assessment of risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?

12.2.1 In summary factors relevant to the assessment of risk for Mr Bayoh would include the same factors as outlined for PC Walker and PC Paton's arrival. Additionally, PC Short witnessed Mr Bayoh being sprayed with CS and PAVA to no effect. This is a significant factor for her to consider for excited delirium warning signs and she should be updating ACR and requesting an ambulance.

12.2.2 PC Tomlinson and PC Short are aware that the two experienced officers PC Walker and PC Paton have arrived ahead of them yet Mr Bayoh has not been contained by them. This should indicate a review of tactics.

12.2.3 There is always a risk to the public if a violent armed person is in a public place. At this time no member of the public is in actual close proximity for immediate risk but the hypothetical person should be a consideration, but not the justification for unnecessary risk.

12.3 What conclusion would a reasonable officer, arriving second at the scene; have reached as to the likely risk (i) to Mr Bayoh; (ii) to the attending officers; and (iii) to the public?
Why?

12.3.1 A reasonable officer arriving at the scene should be concluding that different tactics are required other than general patrol officers. Officers should be considering their training to look for signs of risk of excited delirium and positional asphyxia. Behaviour, bulging eyes and lack of impact of CS and PAVA are clear signs that officers should report to ACR, for the conclusion that specialist engagement is required along with a medical response.

12.4 How would that risk assessment inform the available tactical options?

12.4.1 The tactical options would include:

- **12.4.1.1** Contain rather than restrain;
- **12.4.1.2** Request an ambulance attendance;
- **12.4.1.3** Withdraw, maintain space and continue talking and offering help;
- **12.4.1.4** Follow and observe from a safe distance;
- **12.4.1.5** Await the arrival of the dog unit or ARV;
- **12.4.1.6** Seek guidance from the ACR Inspector;
- **12.4.1.7** Only restrain if the risk of not doing so outweighs the risk of doing so.

13. Question 3(a). Initial contact. Constables Walker and Paton arrive at the locus

- **13.1 General information**
- **13.2 Please categorise Mr Bayoh's offender behaviour[106] at the time of the officers' arrival at the locus**
- **13.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **13.4 What level of response[107] was appropriate?**
- **13.5 What tactical options were open to a reasonable officer?**
- **13.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **13.7 What option(s) would a reasonable officer have chosen? Why?**
- **13.8 On balance of probabilities, had that option been selected, what difference might that choice have made?**
- **13.9 Please categorise[108] and comment on the response(s) by Constables Walker and Paton at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer**
- **13.10 On Day 20, 21 June 2022, at page 91 to 94 inclusive, Constable Paton addressed in his evidence the possibility of an alternative course of action, namely parking in Gallagher's Pub car park, waiting for an Armed Response Unit, observing and monitoring Sheku Bayoh and providing feedback to the Area Control Room and airwaves transmissions to other officers on route. We invite your comments on this possible alternative course.**

---

[106] Chapter 4.6 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a))1 compliance; 2 verbal resistance and/or gestures; 3 passive resistance; 4 active resistance; 5 assaultive resistance; 6 serious/aggravated assaultive resistance

[107] Chapter 4.7 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a)) 1 officer presence; 2 tactical communications; 3 control skills; 4 defensive tactics; 5 deadly or lethal force

[108] See footnote 4

13.1 General information

13.1.1 An officer attending an incident will draw upon their training and experience concerning their initial contact with a person. The officer will consider the sections of the NDM. The first stage requires them to gather information to add to what information they already have. This will involve using all their senses including what they hear and see. Identification of what the incident is, is a crucial element upon arrival, as, for example, the incident may be a crime or welfare incident. A vulnerability assessment of a person is relevant to be conducted. This includes considering:

13.1.1.1 Appearance – How do they look?
13.1.1.2 Behaviour – Is their behaviour appropriate for the environment?
13.1.1.3 Communication – Are they able to communicate effectively?
13.1.1.4 Danger – Is danger being posed by their presence?
13.1.1.5 Environment – Are there specific issues with the environment?

13.1.2 Officers attending a report of a man with a knife need to establish the identity of the subject. Fitting the description is one aspect, but this alone does not confirm identity if there is no knife visible. Identification is one aspect to consider, along with stop and search powers.

13.1.3 Subject behaviour profiling would include:

13.1.3.1 Drugs/alcohol;
13.1.3.2 Eye contact;
13.1.3.3 Age and perceived strength;
13.1.3.4 Possible weapon(s);
13.1.3.5 Potential of danger to others;
13.1.3.6 Escape routes available in the vicinity, if they decide to escape; and
13.1.3.7 Lack of officers to contain Mr Bayoh.

13.1.4 If the subject then refused to engage with officers, intending to continue walking by, this could place him at level 2, at most, of profiled offender behaviour.

13.1.5 An officer should then balance suspect behaviour with impact factors to consider the reasonable officer response. Officers should also notice if the person appears to be influenced in some way, either intoxicated or mental illness. Officers stated that they had considered the fact that the location was near to a hospital which had mental health services.

13.1.6 An officer should then base their response upon the collection of additional information, risk and threat, and policies and procedures. Police actions should always be reviewed throughout the NDM process.

13.1.7 If unarmed officers believe a suspect is armed with a knife, and are unable to avoid contact, they should revert to their use of force training to maintain a distance and speak to the person.

13.2 Please categorise Mr Bayoh's offender behaviour[109] at the time of the officers' arrival at the locus

13.2.1 At the time of arrival for PC Walker and PC Paton, Mr Bayoh's profiled offender behaviour would be, at most, at level 2, "Where a subject verbally refuses to comply with an officer's requests and/or also exhibits body language which indicates non-compliance."[110]

13.2.2 It is not uncommon for police to seek to engage with a person and for them to continue to walk by and not engage. The majority of people do tend to comply with an officer seeking to engage with them, but to not engage could be for a variety of reasons. Reasons could include previous poor encounters with officers, lack of hearing, mental illness, or fear. Alternatively it could be the person is deliberately choosing to ignore the police in an attempt to evade the police.

---

[109] Chapter 4.6 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a))1 compliance; 2 verbal resistance and/or gestures; 3 passive resistance; 4 active resistance; 5 assaultive resistance; 6 serious/aggravated assaultive resistance
[110] Module 1 Section 8 OST Manual

13.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

13.3.1 PC Walker and PC Paton had approximately 7 seconds at the scene, alone, before the arrival of PC Tomlinson and PC Short. As outlined earlier in my report, both officers reported seeing behaviours/physical signs of mental illness and/or intoxication. PC Paton reported comparison with possible drug induced mania.

13.3.2 A reasonable officer's risk assessment for Mr Bayoh at this point should indicate risks associated with potential mental illness and ABD/ED, as per their training. This would indicate risks from a physical restraint of Mr Bayoh for him.

13.3.3 The reasonable officer's risk assessment should recognise the risk to themselves also, if ABD/ED is present Mr Bayoh is unlikely to be easily restrained and may show extreme levels of strength and resistance. This would increase risk to them and him.

13.3.4 The risk of instigating a restraint which fails, may increase the likelihood of the subject escaping in a distressed manner, which may increase risk to the hypothetical member of the public.

13.4 What level of response[111] was appropriate?

13.4.1 The reasonable officer response for a level 2 offender behaviour would be tactical communication. The Police Scotland OST Manual, Module 1 Section 4, concerning tactical communication, states:

> **13.4.1.1** "Information is given out by a combination of voice and body language. To be effective, both need to complement each other."

---

[111] Chapter 4.7 of the Officer Safety Training Manual (PS 10933) and module 1, section 8 of the OST manual (PS11538(a)) 1 officer presence; 2 tactical communications; 3 control skills; 4 defensive tactics; 5 deadly or lethal force

13.4.1.2 "Communication is a two-way process in which people interact with others. When communicating face to face, this information exchange process has 3 components". Then Manual describes words, vocal and body language.

13.4.1.3 "These figures show that clearly the majority of the message is NON-VERBAL. It is, therefore, vitally important that officers learn to use appropriate body language which concurs with what they are saying."

13.4.1.4 "Whilst tactical communication is improved by training and knowledge, the subject's ability to give out and take in information are more likely to be affected by drink, drugs, mental state and behavioural patterns (some learned and some instinctive)."

13.4.2 The OST manual explains the five-step positive style of tactical communication:

13.4.2.1 "STEP 1: ETHICAL APPEAL. Ask. Most people will respond to a direct request from the police."

13.4.2.2 "STEP 2: REASONABLE APPEAL AND EXPLAIN. Explain the reason for the request, what law has been contravened and what conduct caused the request."

13.4.2.3 "STEP 3: PERSONAL APPEAL AND OPTIONS. Explain to the person what they can expect to gain or lose. Options can be created for them. Such options may affect them in terms of time, money, reputation or family."

13.4.2.4 "STEP 4: PRACTICAL APPEAL – CONFIRMATION. This is where the officer confirms the resistance. The subject should be informed of what is required. Following refusal a good recognised phrase is "Is there anything I can reasonably do or say to make you co-operate with me/us?" This easily recognisable phrase also acts as a signal to other officers that this may be the last line of dialogue before taking physical action."

13.4.2.5 "STEP 5: ACTION. A physical force option. This is a necessity because of the subject's continued or escalating resistance. The officer should choose a force option based on their perception of the resistance offered and other impact factors as per the use of the conflict resolution model"

13.4.3 Officers receive input concerning mental ill health and excited delirium within their OST training, which I have explained previously. I believe a reasonable officer would have considered ADB/ED by this stage.

13.4.4 Any form of use of force and restraint can significantly increase risk of death or serious injury to both a detainee and staff. Contain rather than restrain should be a primary objective, where reasonable to do so. This information would be relevant to pass to ACR and the consideration of a medical response.

13.4.5 The reasonable officer should also be aware that CS/PAVA have the possibility of not being effective. The reported bizarre and violent behaviour, the physical look of bulging eyes and appearing intoxicated, and the ineffective use of CS and PAVA should clearly identify to a reasonable officer the consideration of ABD/ED. PC Walker, PC Paton and PC Short all knew that use of CS and PAVA had been ineffective and should have been considering ABD/ED in line with training.

13.4.6 PC Tomlinson stated he was not aware of sprays having been used upon his first encounter. If he did not have any knowledge of sprays having been used he was reliant upon reported behaviour and the physical appearance of bulging eyes. The topic of ABD/ED should still be in his mind but he may be looking for another factor to confirm or refute ABD/ED. He should at least identify possibility of mental ill health and intoxication.

13.4.7 The reasonable officer should also be aware that a detained person suffering a mental health crisis or ABD/ED is less likely to feel pain, and could have increased strength. This should feed into the NDM for tactical planning.

13.4.8 Due to the risk that Mr Bayoh may have a knife, it would be essential for officer safety to maintain a reactionary gap. PC Paton stated that upon arrival Mr Bayoh was walking briskly, and that he considered every knife incident to be a potential terrorism incident. PC Paton had formed the immediate opinion that Mr Bayoh needed to be brought

under control, as he did not know if he did have a knife on him. PC Paton stated he believed it “too big a risk to sit back and contain”. PC Paton stated that Mr Bayoh’s “eyes were bulging out of his head”. This visible factor would indicate the possibility of intoxication, medical illness or mental health crisis, and provided visual information to consider a medical response being required.

13.4.9 PC Paton also stated he was aware that persons on drugs may not feel the temperature, and Mr Bayoh was wearing only a t-shirt when the weather was wet and windy.

13.4.10 Considering the offender profile behaviour and the vulnerability factors attributed to Mr Bayoh, I am of the opinion that keeping distance, for a reactionary gap, and communication was the appropriate initial response required for, at most, the level 2 behaviour. In light of the reports that a knife was being sought, officers would be needing to conduct a stop and search procedure. PC Paton and PC Walker were aware that this was an ‘all patrol’ response and that other officers would be arriving, but were not aware of specialist resources attending. Containing Mr Bayoh with conversation, for the arrival of additional officers would be a reasonable tactical response as there was no knife visible, and no person was currently being endangered.

13.4.11 The listed profiled offender behaviours are contained in the OST Manual and the Use of Force SOP. The OST manual states:
“LEVEL 1 – COMPLIANCE. Large percentages of subjects dealt with are reasonable and will comply with any lawful instruction given by the officer. This compliance may be verbal or it may be active compliance such as stopping when told or showing the contents of their hands.
LEVEL 2 - VERBAL RESISTANCE AND/OR GESTURES. Where a subject verbally refuses to comply with an officer’s requests and/or also exhibits body language which indicates non-compliance.
LEVEL 3 - PASSIVE RESISTANCE. This is non-active conduct with non-compliance: e.g. subject simulates a dead weight / sits or stands and will not move.

LEVEL 4 - ACTIVE RESISTANCE. A form of conduct where the subject actively resists the officer but does not become assaultive: e.g. swallows drugs / runs away from officers / struggles against officers.
LEVEL 5 - ASSAULTIVE RESISTANCE. Physical conduct that results in a direct attack on an officer or person.
LEVEL 6 - SERIOUS/AGGRAVATED RESISTANCE. The highest level of resistance displayed by a subject where there is a possibility of serious injury and/or death. This could include the production of a weapon of any kind."

13.5 What tactical options were open to a reasonable officer?

13.5.1 Tactical options included:

13.5.1.1 Withdraw from the scene, and report back to ACR to seek additional instruction.

13.5.1.2 RV Point allocation and muster.

13.5.1.3 Maintain distance from Mr Bayoh, and ask if he needed medical assistance.

13.5.1.4 Maintain distance from Mr Bayoh, and direct him to stop and speak.

13.5.1.5 Maintain distance from Mr Bayoh, direct to stop and state intentions to conduct a stop and search procedure for the purpose of finding a knife.

13.5.1.6 Covert handling of incapacity spray whilst engaging in communication.

13.5.1.7 Baton ready-to-draw position whilst engaging in communication.

13.5.1.8 Updating ACR and attending patrols.

13.6 Please identify all factors relevant and material to your assessment of the option(s) available

13.6.1 Relevant materials and factors include:

13.6.1.1 Upon initial contact Mr Bayoh had not been positively identified as the subject they were looking for. There was a possibility it was not him;

13.6.1.2 Mr Bayoh's behaviour, upon initial arrival, was not violent, or threatening violence;

13.6.1.3 No knife was visible;

13.6.1.4 Stop and search procedures could have been considered for use;

13.6.1.5 Initial contact, use of force and arrest are all part of 'custody' and are covered by the "Care and Welfare of Persons in Custody" SOP;

13.6.1.6 Mental health;

13.6.1.7 Intoxication and intoxication induced ABD/ED;

13.6.1.8 Medical/first aid;

13.6.1.9 Armed Policing SOP;

13.6.1.10 OST manual;

13.6.1.11 Use of Force SOP;

13.6.1.12 Public Order SOP; and

13.6.1.13 Police Dogs SOP.

13.7 What option(s) would a reasonable officer have chosen? Why?

13.7.1 The reasonable officer would use their training and guidance to maintain safety for themselves, Mr Bayoh and the public. Mr Bayoh clearly showed signs of vulnerability with 'bulging eyes' which is likely to require a medical intervention if he remains with police. Officers need to ascertain if he is the person they are looking for, and if he is in possession of a knife.

13.7.2 Officers should attempt to establish if he is in need of medical care, as medical care takes priority over the detention.

13.7.3 As explained earlier the options to withdraw, feedback to ACR, observe and muster at an RVP is still a viable option.

13.7.4 Stop and search powers would be applicable to search for the knife, and a person can be detained for the purpose of the search. Minimum amount of force necessary can be used to conduct the stop and search. Calling for an ambulance should not be delayed for the purpose of stop and search.

13.7.5 No person has reported being the victim of a crime at this point, so the initial investigation is concerning the possession of the knife. However, there is always the possibility of a currently unknown victim and officers should be mindful of forensic evidence. This means if Mr Bayoh has attacked a person with the knife there may be forensic evidence on him from the crime scene which could be lost if this issue is not considered. Alternatively, if he has been the victim of a crime prior to police involvement there could be forensic evidence on him from the offenders. If officers were to provide first aid to Mr Bayoh they should consider any signs of injury or blood upon him from both the possibilities that he could be a victim of crime or an offender of crime.

13.7.6 The attendance of a police dog would greatly benefit the containment and security for the purpose of search. If the knife has been discarded, the dog can be used to find the weapon[112]. A common deployment of a police dog is to trace articles. PC Wood explained that a main task of the dog is to recover property.

13.7.7 Police dogs are successful at containing and assisting in the detention of a violent person. PC Wood explained that dogs are there to deal with violent offenders[113]. They can overpower the subject by taking hold of the arm and taking the person to the ground. The simple presence of the dog can encourage persons to throw down their weapon and take to their knees for handcuffing.

13.7.8 Fears that Mr Bayoh was a large and strong man could be mitigated with the presence of a police dog, as their presence can often prevent violence and resistance. Seeking an update from the ACR concerning a dog handler would be a reasonable option.

[112] SBPI-00108 PC Gary Wood Section 64-66 inclusive
[113] SBPI-00108 PC Gary Wood Section 41-49 inclusive

13.8 On balance of probabilities, had that option been selected, what difference might that choice have made?

13.8.1 Tactical options included:

13.8.1.1 Withdraw from the scene, and report back to ACR to seek additional instruction. This would allow the ACR Inspector to review his involvement for the tactical plan. With his level of training he should be mindful of risks such as ABD/ED and the control measures available. This would allow immediate review concerning the deployment of the dog handler.

13.8.1.2 RV Point allocation and muster. This would allow officers to meet to enable a tactical plan agreement and all officers to attend together, as a group larger than 2. A larger group could facilitate containment.

13.8.1.3 Maintain distance from Mr Bayoh and ask if he needed medical assistance. This may have obtained a co-operative response, or may not have. It could have permitted additional information to be obtained, and indicate a non-threatening interaction with Mr Bayoh.

13.8.1.4 Maintain distance from Mr Bayoh, and direct him to stop and speak. A tactical option and although likely not to achieve any compliance, would provide additional feedback for the NDM process.

13.8.1.5 Maintain distance from Mr Bayoh, direct to stop and state intentions to conduct a stop and search procedure for the purpose of finding a knife. As above, possibly would not achieve a co-operative response but would provide additional information.

13.8.1.6 Covert handling of incapacitant spray whilst engaging in communication. Covertly holding the CS/PAVA would afford a level of protection to the officers without overtly communicating use of force.

13.8.1.7 Baton ready-to-draw position whilst engaging in communication. Would provide a level of protection to officers but likely to indicate to Mr Bayoh the intention to use force.

13.8.1.8 Updating ACR and attending patrols. This would permit other officers to provide input, particularly the dog unit who was of the opinion he could positively assist at this incident.

13.8.2 Knowing that a dog handler could be only minutes away could have made a difference regarding the necessity for officers to use force. PC Walker and PC Paton did not know that a dog handler could attend. I am of the opinion if a reasonable officer knew that a dog unit was only minutes away, as no imminent threat was posed to a member of the public, it would be a safer practice to await the dog unit's arrival and in the meantime keep distance, observe and feedback information.

13.9 Please categorise[114] and comment on the response(s) by Constables Walker and Paton at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer

13.9.1 Officers Paton and Walker's tactics were discussed by them prior to their arrival at the scene, and both officers had prepared themselves for immediate use of force. Both officers exited the vehicle prepared to use force to gain control of Mr Bayoh. Officers must always be mindful that tactics are fluid and are to be constantly reviewed to ensure they are necessary, reasonable and proportionate.

13.9.2 The fact that Mr Bayoh did not have the knife visible when they arrived, the tactic for using force, should have been reassessed using the NDM and ACR updated.

13.9.3 A reasonable officer would arrive and assess what they could see, but be prepared to escalate their response as and when necessary. As no knife was visible and Mr Bayoh was displaying, at most, a level 2 behaviour of non-compliance a reasonable officer would attempt engagement by communication from the van, or if they did feel it necessary to

[114] See footnote 4

exit the vehicle to maintain distance for a reactionary gap. I am of the opinion that a reasonable officer being aware of the visible risk factors, and lack of visible knife would have distanced themselves from Mr Bayoh and provided feedback to the ACR. The officer would seek an update for the dog handler and other patrols. As no member of the public was in immediate danger the reasonable officer would be considering their safety and Mr Bayoh's safety. If they believe a knife may be hidden on the person, to attempt to engage a person who is showing signs of mental health crisis/ABD/ED is dangerous and places all parties at risk.

13.9.4 PC Paton stated that he immediately got out of the van with his CS drawn, and shouted for Mr Bayoh to "Get yourself down on the fucking ground" whilst holding his incapacitant spray in a 'ready to fire' position. PC Paton stated he could see Mr Bayoh's "bulging eyes" and that Mr Bayoh was staring through him. Immediately seeing signs of such intoxication, PC Paton should have reassessed his response options using the NDM process.

13.9.5 Seeing Mr Bayoh with "bulging eyes" would increase the risk, and officers should have considered this. This may be a violent deranged person, commonly referred to as 'angry man' scenario in officer safety training. Such a person requires specialist handling.

13.9.6 There only being two officers present, it is unsafe to proceed with a physical intervention unless the risk of not doing so, outweighs the risk of doing so.

13.9.7 As explained in section 8 of this report, officers are taught that any subject exhibiting symptoms of Excited Delirium should be treated as a medical emergency. PC Walker, PC Paton and PC Short should have identified the lack of response to CS and PAVA, in addition to his physical appearance, as sufficient confirmation to suspect an ambulance was required. If PC Tomlinson believed that PC Walker had been slashed with a knife he should have been updating ACR of this suspicion and requesting an ambulance.

13.9.8 Officers would be taught to continue attempts at verbal communication and containment, and as Mr Bayoh's behaviour is still only at level 2, space and communication is still a viable tactical option. Communication is not simply about shouting commands at a person. This would include appropriate and tactical communication. Communication styles should be flexible subject to the person you are trying to communicate with. Officers are taught that communicating with a person in mental health crisis includes being calm and indicating no threat. A person may have English as a second language and not easily understand. A person could be hearing impaired. A person may have a learning disability.

13.9.9 The reasonable officer would continue with distance, communication, containment, updating ACR, but in a state of preparedness to escalate their tactical response if required, and await additional resources and direction from ACR.

13.9.10 From their arrival at 07:20:23 to PC Paton's emergency button being pressed at 07:20:42 is a period of 19 seconds. During this 19 seconds PC Paton discharged his CS and PC Walker discharged his PAVA. If PC Tomlinson's account is correct and these had been discharged by his arrival, this means CS and PAVA were discharged within 7 seconds of PC Paton and PC Walker's arrival. If the CS was full at the commencement of the discharge and fully discharged, this would take approximately 6 seconds to empty.

13.9.11 The use of the CS and PAVA was within 19 seconds of arrival, and potentially within 7 seconds, based upon what was described as a level 2 offender profiled behaviour. According to PC Paton, Mr Bayoh had his palms out and his hands were not in a fist, and he was clearly showing signs of intoxication and/or mental ill health. In my opinion, a reasonable officer initial response would have been to keep distance, consider whether withdrawing was appropriate and if not appropriate to attempt to talk, not shout commands. This would allow an essential delay to update ACR and permit other officers to arrive. This would be based upon officers recognising that Mr Bayoh appeared to be displaying warning signs of ABD/ED and may be in possession of a knife.

13.10 On Day 20, 21 June 2022, at page 91 to 94 inclusive, Constable Paton addressed in his evidence the possibility of an alternative course of action, namely parking in Gallagher's Pub car park, waiting for an Armed Response Unit, observing and monitoring Sheku Bayoh and providing feedback to the Area Control Room and airwaves transmissions to other officers on route. We invite your comments on this possible alternative course

13.10.1 Yes, I agree with this option. Unarmed, non-specialist officers should not have deployed directly to Mr Bayoh. As explained earlier in my report, I believe officers should have been diverted to an RV point to observe, await additional resources and receive an updated tactical plan. Additional patrols arriving and at least one dog handler, within 10 to 15 minutes away, could have been deployed under a managed, and controlled, tactical plan. Officers did have the discretion to request an RV point be allocated for resources to muster. There is also a 'mobile muster' which would allow officers to slowly drive, or pull over, and allow others to gain distance so several vehicles can attend at the same time. Officers must also make their own dynamic risk assessment upon approaching a scene and if they believe the risk is unacceptable they can challenge the deployment, and select the appropriate tactical option such as stop short of the scene to observe or drive by.

14 Question 3B Constables Tomlinson and Short

- **14.1 General information**
- **14.2 Please categorise Mr Bayoh's offender behaviour at the time of the officers' arrival at the locus**
- **14.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **14.4 What level of response was appropriate?**
- **14.5 In light of the apparent actions already taken by Constables Walker and Paton, what tactical options were open at that stage to a reasonable officer arriving at the scene?**
- **14.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **What option(s) would a reasonable officer have chosen?**
- **Why?**
- **14.7 On balance of probabilities, had that option been selected, what difference might that choice have made?**
- **14.8 Please categorise and comment on the response(s) by Constables Tomlinson and Short at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer**

14.1 General information

14.1.1 Officers arriving at the scene of incidents are required to consider their tactical responses within the NDM. They should be informing control that they are arriving and update regarding what they see. Any use of force must be based upon their assessment of the risk and threat.

14.1.2 Officers must have regard to:

14.1.2.1 The OST training and manual;

14.1.2.2 Use of Force SOP; and

14.1.2.3 Care and Welfare of Persons in Police Custody SOP.

14.1.3 PC Tomlinson and PC Short arrive approximately 7 seconds after PC Walker and PC Paton. Their accounts differ regarding the timeline. PC Tomlinson believes his initial arrival coincided with him seeing PC Walker appearing to have been slashed. This would mean that CS and PAVA had already been discharged. PC Short believes their arrival was coinciding with PC Walker and PC Paton in a face-to-face standing position with Mr Bayoh, prior to any CS and PAVA being used.

14.2 Please categorise Mr Bayoh's offender behaviour at the time of the officers' arrival at the locus

14.2.1 PC Short recorded in her PIRC statement[115]: "Craig and Alan's van was parked near the bus stop and they were both out of the van and both had their sprays out. They were shouting at a huge, very muscular black guy around 6ft tall wearing a tight t-shirt and charcoal jeans. Craig and Alan were shouting at him to stop but he kept moving towards them with his first clenched out at his side. He had a crazed look about him and I was in no doubt that he was going to attack them. Alan and Craig were screaming at the guy shouting "get back, this is CS spray, get back or I will spray you". PC Short describes behaviour which caused her to believe Mr Bayoh was at level 4 - active resistance profiled offender behaviour heading to level 5 - assaultive resistance. If Mr Bayoh was moving towards the officers with fists clenched it would be reasonable for her to believe he was preparing to punch an officer. Additionally, she described his 'crazed look' which could evidence mental ill health crisis and/or warning signs for ABD/ED.

14.2.2. PC Tomlinson in his PIRC statement[116]recorded that he "saw a black guy on the pathway which cuts the corner between Hayfield Road and Hendry Road, same side as bus stop. I saw this male walking directly at Craig Walker at the passenger side of his van

[115] PIRC-00253
[116] PIRC-00263

face to face. I didn't see Alan Paton." And "I saw Craig lift his hands to his face and my first thoughts were that he had been slashed because of the mention of a knife on airwave. As soon as Craig held his face, the black guy turned away and did a bouncy type of walk which was almost like he had won a victory or something. He strutted along the pathway. I shouted "desist" and he turned round to look at me with a kind of dirty look. I shouted for him to stop and I didn't know whether he had a knife or not. I followed him to the path at the shrubbery. I was parallel with him". If PC Tomlinson believed that Mr Bayoh had slashed the officer with a knife this would be level 6 - serious/aggravated assault, on the offender profile.

14.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

14.3.1 Concerning PC Tomlinson's account, I am of the opinion that a reasonable officer arriving, and seeing what they believed to be a colleague slashed with a knife would consider this to be level 6 offender behaviour. They would be calling upon the ACR for urgent ambulance attendance and calling words similar to "officer down". The priority would be the preservation of life of their colleague. An immediate attendance to PC Walker to establish his condition, and protect him from further attack would be a reasonable officer response. As explained earlier in this report, Mr Bayoh could be allowed to flee the scene, with police dogs and ARV staff being summoned to track and detain Mr Bayoh. Unarmed officers are not mandated to risk their lives to attempt an early arrest.

14.3.2 Concerning PC Short's account, I am of the opinion a reasonable officer arriving would see two officers preparing to CS and PAVA a person who is moving towards the officers with clenched fists preparing to attack them. Officers deploying defensive tactics against such a threat would be reasonable.

14.3.3 PC Paton stated that Mr Bayoh did not approach him with clenched fists, which differs to PC Short's account.

14.3.4 A reasonable officer must take into consideration information which they have collected from various information sources. These sources will include what ACR has told them, plus what they can see, hear, and feel. They must use the NDM to consider the powers and policies to create their options and contingencies.

14.4 What level of response was appropriate?

14.4.1 Even though PC Tomlinson believed that Mr Bayoh had slashed PC Walker with a knife to the face, and the whereabouts of PC Paton were unknown, he recorded[117]: "I shouted "desist" and he turned round to look at me with a kind of dirty look. I shouted for him to stop and I didn't know whether he had a knife or not. I followed him to the path at the shrubbery. I was parallel with him" and "I got my CS Spray out but I could not see a knife. I thought Craig had been slashed. The black man did not say anything and his fists were clenched. I sprayed my CS at him from about 4 or 5 metres away from him." At the time of spraying PC Tomlinson does not indicate Mr Bayoh's behaviour is displaying a threat of violence towards him.

14.4.2 No call was made for 'officer down' or an ambulance. PC Tomlinson did not go to PC Walker to offer first aid or attempt to locate PC Paton. No verbal shout was called over to PC Walker to establish his level of injury.

14.4.3 PC Short recorded [118]: "I have never ever seen a more frightening crazy man in my life and I could see he was completely out of control" and "Alan and Craig had no option but to spray him and they did so as I jumped out of the van. I watched the guy laughing at them as he wiped it off his face and turned and walked away from the van. I remember Craig shouting "Alan it's no fuckin working". The guy then started walking past us up a path between trees and bushes."

[117] PIRC-00263
[118] PIRC-00253

14.4.4 PC Short provides an account which indicates Mr Bayoh may be intoxicated and/or suffering a mania or mental health crisis. She states they commenced spraying as she jumped out of the van, which would mean this was just over 7 seconds since their (PC Walker and PC Paton) arrival at scene, and their attempts to de-escalate was around 7 seconds.

14.4.5 The reasonable officer response within the OST manual would include consideration of defensive tactics and deadly or lethal force if they honestly believed an officer had been stabbed/slashed, and they needed to defend that officer, or another officer, from a continuation of the attack. The lawful use of force by officers includes the overriding principle that it must be reasonable and necessary. The officer must also have an honestly held belief that they, or another, are in imminent danger of attack. This highlights the need for some evidential basis for the officer's belief and would therefore require justification. It would be reasonable to take steps to ascertain if PC Walker had been slashed or not.

14.4.6 PC Tomlinson reported that Mr Bayoh walked away, and it appears he was not continuing an attack on the officers. PC Tomlinson's use of force would now have been in order to arrest Mr Bayoh. With the belief that PC Walker was slashed/stabbed, and PC Paton's whereabouts unknown, a reasonable officer response would be to tend to the injured colleagues to save their lives and allow Mr Bayoh's exit from the scene. Specialist officers would be required to detain Mr Bayoh. Preservation of life to tend to those injured would be the priority.

14.4.7 The reasonable officer response within the OST manual if it was considered that Mr Bayoh had walked away from officers, in possession of a knife, having been sprayed with CS and PAVA without effect, would be to tend to casualties, continue to attempt to maintain distance from Mr Bayoh and report back to ACR for tactical advice, and seeking additional specialist resources.

14.5 In light of the apparent actions already taken by Constables Walker and Paton, what tactical options were open at that stage to a reasonable officer arriving at the scene?

14.5.1 Tactical options available to PC Short and PC Tomlinson would include:

14.5.1.1 Allow Mr Bayoh to proceed away from the scene and attend to the colleague who is believed to be injured, and locate PC Paton. Provide immediate first aid and ensure an emergency ambulance response had been activated, or establish that officers have not been slashed and update ACR accordingly.

14.5.1.2 All four officers retreat to a place of safety, reporting to ACR for assistance and notifying which way Mr Bayoh has proceeded, so that specialist officers can be engaged for deployment.

14.5.1.3 Attempting to make an arrest, considering the risk of the officer(s) being seriously injured, and risk to Mr Bayoh who is clearly showing signs of medical concern.

14.5.1.4 Officers are trained to contain, rather than restrain, persons who are showing medical warning signs. However, as two officers are now incapacitated it is reasonable for officers to withdraw from contact and update ACR accordingly. The risk is too high for both officers and Mr Bayoh. Although a risk to the hypothetical member of the public still exists, an additional tactical plan is required to deal with this.

14.5.1.5 Attempting to engage Mr Bayoh by keeping distance, and speaking to him was also an option.

14.5.1.6 Requesting an ambulance for Mr Bayoh.

14.5.1.7 Making enquiries at the nearby hospital for any mental health patients being absent.

14.6 Please identify all factors relevant and material to your assessment of the option(s) available . What option(s) would a reasonable officer have chosen? Why?

14.6.1 Relevant factors would include:

14.6.1.1 Guidance documents such as SOPs for Use of Force, Armed Policing Operations, Police Dogs, Care and Welfare of Persons in Police Custody.

14.6.1.2 The OST Manual

14.6.1.3 The NDM.

14.6.1.4 Mr Bayoh is showing physical warning signs which the officers should be interpreting as possible signs of ABD/ED

14.6.1.5 Two officers are now incapacitated, and the continuation of PC Short and PC Tomlinson to engage is likely to involve further injury.

14.6.1.6 Two officers will be unable to contain a person in a public place, and their presence could risk the subject being panicked into involving members of the public.

14.6.1.7 Officers are aware that a mental health unit is nearby, and the subject could be associated with that unit.

14.6.1.8 This is a situation which meets the armed response SOP statement “this may include situations where the subject is not in possession of a firearm or other potentially lethal weapon but is otherwise so dangerous that the deployment of police firearms resources may be required to safely control the situation”. [119]

14.6.1.9 This is a situation which also meets the criteria of a violent/deranged person for a public order response by PSU trained officers, who would be able to engage shields.

14.6.1.10 This is a situation which meets the criteria for deployment of a police dog.

---

[119] Section 8.4.1 - Armed Policing SOP

14.6.2 The reasonable officer should recognise that this is beyond their level of competence, for their safety and that of Mr Bayoh, and be seeking tactical direction from ACR. In the interim they should withdraw from Mr Bayoh and keep observations.

14.7 On balance of probabilities, had that option been selected, what difference might that choice have made?

14.7.1 Had the officers withdrawn to a place of safety and passed information to ACR, risks would have still existed for Mr Bayoh and members of the public who may have become involved with him. However, this withdrawal could have been short term for a tactical plan to be created and officers to RV. A managed intervention could then be agreed, with relevant specialist resources, and have an ambulance on standby.

14.7.2 The risk of officers continuing to confront Mr Bayoh increased the risk of harm to them and the displacement of Mr Bayoh, with increased risk of escalating his behaviour towards the public. An intervention needed to be managed which would increase the chances of it being successful.

14.8 Please categorise and comment on the response(s) by Constables Tomlinson and Short at Hayfield Road. In particular, indicate to what extent, if any, their response(s) differed to that of a reasonable officer

14.8.1 PC Short and PC Tomlinson initially attempted to maintain a distance and use tactical communication to Mr Bayoh.

14.8.2 PC Tomlinson opted to use his CS against Mr Bayoh, whilst Mr Bayoh was walking away, and whilst he reportedly had clenched fists. Mr Bayoh had not been informed that he was under arrest at this point.

14.8.3 PC Tomlinson reported that the CS had no effect upon Mr Bayoh. This would be a risk factor when CS has no effect on a person. It can indicate significant intoxication or mental health crisis. This would be relevant new information for PC Tomlinson to take into consideration for tactical options. At this point PC Short would now be aware that three officers have discharged spray towards Mr Bayoh, with no effect. This would be a critical factor for her to report to ACR and PC Tomlinson. In my opinion, a reasonable ACR Inspector, knowing of three spray discharges, in addition to Mr Bayoh's physical presentation is likely to direct officers to withdraw from the engagement. PC Tomlinson now aware of his CS having no impact, in addition to the physical appearance, should be consciously aware now of ABD/ED warning signs and updating ACR.

14.8.4 PC Tomlinson recorded:[120] "I got my baton out and drew it to the high carry position with my right hand. The man started to run in my direction but then veered right, straight towards where Nicole was. She was running across the road away from the bus stop.

14.8.5 "He caught up with her and punched the back of her head. She didn't have her police hat on and neither did I. She fell to ground face down when he punched her and she tried to protect her head and push herself up with her hands at the same time. I ran over to assist her".

14.8.6 The punch to PC Short's head describes offender profile behaviour of level 6, serious/aggravated resistance. The reasonable officer response to this level of behaviour includes defensive tactics and, if necessary, reasonable and proportionate deadly or lethal force.

14.8.7 A single strike to the head can prove fatal, and officers are taught that the head area is coded 'red' for the highest level of risk. Head injuries are described further in section 15 of this report.

---

[120] PIRC-00263

14.8.8 Three of the four officers at the scene are now incapacitated to various levels, and PC Tomlinson is now acting alone. I believe the reasonable officer would be calling for urgent assistance, and use their personal protective equipment to protect themselves and their colleagues. PC Tomlinson has his baton available to use. The reasonable officer would use their baton in this situation for self-defence. PC Tomlinson has reported he believes PC Walker slashed, PC Paton's whereabouts unknown and PC Short punched to the back of her head with such force that knocks her to the ground.

14.8.9 PC Tomlinson has his baton available for use. The strike target area would then be based upon availability and threat. The OST manual shades the body between green and red areas. Red areas such as the head, indicate high risk areas whereby a strike can cause disability or fatal injury. The primary strike areas are typically taught as being the arms or thighs. A person in acute crisis may not be affected by pain, as they do not react to pain in the same way as a person not affected by a crisis or intoxication. However, a baton strike does not rely upon the person feeling pain. Baton strikes work on a principle tactic of 'hit and stick', also referred to as kinetic energy, to transfer the majority of the energy from the baton into the strike point. The application of a strike to a major muscle group (thigh or upper arm) can produce motor dysfunction. This term is specifically used to define an over-stimulation of motor nerve points throughout the human body. This may result in temporary muscle impairment. In effect, such a technique may physically shut down a limb temporarily so that it is incapable of being used. An intoxicated person may not feel pain, but the limb may still be temporarily incapacitated, as the strike works primarily on the localised nerve and not on the pain response in the brain. The 'motor dysfunction' effect is reliant on the concept of 'time on target'. It means that when applying a strike to a motor point, the officer hits and momentarily sticks the strike onto the target. This is likely to stimulate underlying nerve tissue much more effectively. Officers should be informed of these basic principles during training, and is included in the baton training delivered in England.

14.8.10 The baton strike chart for red, yellow, green is available at Appendix E. The baton may be used in self-defence, to protect others, or to effect the arrest/detention of a person. The selected target area should equate to the level of resistance offered by the subject.

14.8.11 The use of batons, and training, has evolved over the years. It was 1994 when the use of batons was first authorised in the UK. These gradually replaced the wooden truncheons throughout forces. Initially officers were trained to use the batons to block, strike and assist in arm-locks and take down techniques. The techniques were imported from America, and many techniques were considered too technical for safe application. Blocks and strikes became the common use for batons, with a small selection of arm-locks and takedowns.

14.8.12 The Police Scotland OST Manual[121] disclosed to me states: "Officers will be able to demonstrate all the techniques included within the straight baton programme."

14.8.13 For knife defence the OST manual states: "When all options have been exhausted and the CUT principle is not an option, an officer can defend themselves with their baton against an edged weapon. [redacted]

[redacted]

[122]

14.8.14 The body is colour-coded for primary and secondary target areas (see Appendix E). The officer must be aware of the medical implications of striking various target areas on the subject in order to justify their intended actions:

14.8.14.1 Based on the red, yellow and green body system: Primary target areas are large muscle mass areas such as arms and legs. Secondary target areas increase the risk of harm and involve striking joints such as knees and elbows, the groin or the torso – excluding the red areas of spine, solar plexus, heart, neck and head. The red areas are then a third category.

14.8.14.2 Based upon the Police Scotland red and green body system[123]: Primary target areas are large muscle mass areas such as arms and legs, including knee

[121] PS11538(a) Module 6 Section 1.
[122] OST Manual Module 6 Section 10.
[123] Use of Force SOP

and elbow joints. Secondary target areas are all red areas including the head. In the 2017 version of the OST Manual the same red and green chart is used but with added phrases including: “Blows to the head carry the highest risk of trauma with possibility of death or serious injury and lasting disability. For this reason the entire head is a red area. It may be struck only when use of deadly force is justified.”

14.8.15 Section 7.2 of the Use of Force SOP covers the 8 guidelines for dynamic risk assessment as being: remember your duty to protect and preserve human life; be aware of physical limits and do not take risks; tell someone what you are doing and try to get support before you do it; heed information and advice; apply correct procedures in every situation; record your decision soon afterwards; your supervisors and managers are there to help you; making a proper judgement in good faith will not be criticised.

14.8.16 PC Short recorded that she witnessed Mr Bayoh being sprayed by officers Paton and Walker. She did not believe they had been slashed by a knife. She recognised the officers were incapacitated by the spray they discharged at Mr Bayoh. She also witnessed PC Tomlinson discharge his CS at Mr Bayoh and it had no effect on Mr Bayoh. She stated that she drew her baton against Mr Bayoh. This would be a reasonable officer response to the threat in front of her. She recorded[124]: “I shouted to the guy "get down on your knees and put your hands behind your back". I was in complete Tulliallen mode and that was all I could think to say”. (This would be referring to being in police training mode.)

14.8.17 PC Short then recorded “He then bizarrely and very quickly boxer skipped towards me as if he was in a boxing ring. I was in terror as he came at me and only me and I could see his muscles totally pumping. I knew he was going to kill me. I was shouting "get back or I'll strike" as I tried to create more space between us. I swiped my baton in a fend-off motion in front of me to try and create space. I know this might sound stupid but I didn't want to hit him however he just kept coming towards me. I looked at his face and

[124] PIRC-00253

remember the determination and anger in it. There was no doubt he was going to attack me and kill me. In terror and in fear for my life I just turned and tried to run away."

14.8.18 PC Short stated she attempted to move away from the threat, which is a tactical option. It would also have been a reasonable officer response to strike Mr Bayoh with her baton, aiming for a primary or secondary target area if she believed he was about to seriously assault her.

14.8.19 In relation to training and reasonable officer responses, the incident having incapacitated both PC Paton and PC Walker, it would be reasonable for PC Tomlinson and PC Short to tend to the safety of their colleagues and themselves, inform control, and retreat to an RV point. They opted for the tactical response of tactical communication by 'mirroring' Mr Bayoh as he walked. This was also a reasonable officer response. When Mr Bayoh moved to attack PC Short it was a reasonable officer response for her to use the police baton for self-defence.

14.8.20 Strikes to the head are not taught as primary target areas. Police Scotland taught them as a secondary target area. PC Short's use of the baton to define distance between her and Mr Bayoh was a reasonable officer response, so too would have been her striking him to a primary target area as he came towards her if she feared he was attacking her. Any strike to the head could be fatal to the person being struck. See below concerning head injuries.

15. Question 4. Assault of Nicole Short

Question 4 Hypothesis 1: punch to back of head (no stamp)

- **15.1 General information**
- **15.2 Please categorise Mr Bayoh's offender behaviour at the time of the assault**
- **15.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **15.4 What level of response was appropriate?**
- **15.5 What tactical options were open to a reasonable officer?**
- **15.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **15.7 What option(s) would a reasonable officer have chosen? Why?**
- **15.8 On balance of probabilities, had that option been selected, what difference might that choice have made?**
- **15.9 Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer**

15.1 General information

15.1.1 Officers are trained to understand the head area is a 'red' area for medical risks. Head injuries are covered in several leading UK wide publications which include:

15.1.1.1 The Faculty of Forensic and Legal Medicine (FFLM) 'Head Injury Warning' 2011 publication.[125]

[125] https://fflm.ac.uk/wp-content/uploads/2020/10/ARCHIVED-Factsheet-Head-Injury-Warning-July-2011.pdf

15.1.1.2 The National Institute for Health and Care Excellence (NICE) 'Head Injury: Assessment and Early Management' Published 22nd January 2014.[126]

15.1.1.3 Guidance from the BMA Medical Ethics Department and the Faculty of Forensic and Legal Medicine 'Health care of Detainees in Police Stations' Published February 2009.

15.1.2 The use of batons to the body is commonly colour-coded into either red and green; or red, yellow, green. The Monadnock baton strike chart[127] uses red, yellow and green. Cumbria Police were using this chart as the use of force training aid until I left in 2013. Both variations show the head area as being red. Red means the highest risk to strike. The red area is the "highest level of resultant trauma. Injury tends to range from serious to long lasting" and "may include unconsciousness, serious bodily injury, shock or death"[128]. Officers must be aware of medical implications for striking the head area. The risk of death or disability to the subject must be understood and assessed against the risk of not doing so.

15.1.3 Policing priorities when attending incidents includes the protection of life, as a primary objective, and this includes protecting police officer lives.

15.1.4 Medical attention should be sought for any person who receives a trauma impact to the head, at a police incident. This will include officers, subjects and members of the public. It is important that the ACR are updated as soon as practicable of a head strike.

15.1.5 If an officer is punched, knocking them to the ground, this would be assaultive behaviour as per the profiled behaviour. As per the information concerning head injuries, such a significant blow could prove fatal or cause disabilities to the officer. A reasonable officer response would include the use of force to the primary green target areas. However, it may be reasonable, subject to NDM and risk, to consider an escalation in

---

[126] https://www.nice.org.uk/Guidance/CG176
[127] See Appendix E
[128] Monadnock Baton Chart

response to include secondary target areas. Secondary target areas are listed in the Use of Force SOP[129] as including the bridge of nose, upper lip, abdomen, solar plexus, and groin. These are shown as red areas on the Police Scotland body map.

15.1.6 The victim of a head strike requires immediate first aid response, and medical attention as soon as practicable as complications from a head injury are not always immediately obvious.

15.1.7 The death of Mr Christopher Alder in police custody[130] is a case study used by many, within the UK police service, since 2006. Mr Alder had been punched once and knocked to the ground. He later died in police custody and this case was used to emphasise the dangers associated with head injuries.

15.1.8 The Police Scotland Care and Welfare of Persons in Police Custody SOP states: "Staff must be aware of the risks associated with head injuries particularly when dealing with custodies who may have been involved in a fight or a road traffic collision. A head injury may result in a rapid deterioration in the health of the custody. Medical assistance must be sought in all instances of head injuries."[131]

15.1.9 Appendix T is then listed for additional information. Appendix T states:

> **15.1.9.1** "Head injuries can cause acute behavioural disturbance due to cerebral irritation. Sedation and treatment in hospital will normally resolve the condition within hours. A blow to the head can result in bruising or bleeding inside the skull or inside the brain; not all head injuries are visible. Complications may occur at any time after the event."
>
> **15.1.9.2** "The National Institute for Clinical Excellence (NICE) advises that where any of the following signs are present after the individual has sustained a head

[129] PS10933
[130] See Report section 20 for additional information
[131] Section 15.19

injury, an ambulance should be called immediately: • Unconsciousness, or lack of full consciousness (for example, problems keeping their eyes open);"

15.1.10 A comparable instruction exists within the 2012 College of Policing guidance 'The Safer Detention and Handling of Persons in Police Custody'[132]. Head injuries are specifically covered in section 3.3.6 and states: "Detainees who have suffered a head injury should be immediately transported to hospital for medical assessment and monitoring. A blow to the head can result in bruising or bleeding inside the skull or inside the brain; not all head injuries are visible. Complications may occur at any time after the event. Staff must be aware of the risks associated with head injuries, particularly when dealing with Detainees who may have been involved in a fight or a road traffic collision; a head injury may result in a rapid deterioration in the health of the detainee. Custody officers and staff should be guided by the FFLM Head Injury Advice Leaflet for Custody Officers, Gaolers & Detention officers when dealing with a detainee who is exhibiting symptoms of a head injury. This may be the case even where there is no obvious sign of injury, or when/if the detainee denies that any injury has occurred."

15.1.11 The National Institute for Health and Care Excellence (NICE) 'Head Injury: Assessment and Early Management'[133], published January 2014, states that:

15.1.11.1 "This guideline covers the assessment and early management of head injury in children, young people and adults. It promotes effective clinical assessment so that people receive the right care for the severity of their head injury."

15.1.11.2 "Head injury is the commonest cause of death and disability in people aged 1 to 40 years in the UK."

15.1.11.3 "Ninety-five per cent of people who have sustained a head injury present with a normal or minimally impaired conscious level."

---

132 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf

133 https://www.nice.org.uk/Guidance/CG176

15.1.11.4 "For adults who have sustained a head injury and have any of the following risk factors, perform a CT head scan within 1 hour of the risk factor being identified: — GCS[134] less than 13 on initial assessment in the emergency department — GCS less than 15 at 2 hours after the injury on assessment in the emergency department. — Suspected open or depressed skull fracture. — Any sign of basal skull fracture (haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign). — Post-traumatic seizure. — Focal neurological deficit. — More than 1 episode of vomiting."

15.1.11.5 A "High-energy head injury. For example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 metre or more than 5 stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorised recreational vehicles, bicycle collision, or any other potentially high-energy mechanism."

15.1.11.6 "emergency transport to the emergency department if they have experienced any of the following:

- Unconsciousness or lack of full consciousness (for example, problems keeping eyes open).
- Any focal neurological deficit since the injury.
- Any suspicion of a skull fracture or penetrating head injury.
- Any seizure ('convulsion' or 'fit') since the injury.
- A high-energy head injury."

15.1.11.7 "GPs, nurse practitioners, dentists and ambulance crews should receive training, as necessary, to ensure that they are capable of assessing the presence or absence of the risk factors listed in recommendations."

15.1.12 Section 1.1.1 of the NICE guidance states: "Public health literature and other non-medical sources of advice (for example, St John Ambulance, police officers) should

[134] GCS – Glasgow Coma Scale

encourage people who have any concerns following a head injury to themselves or to another person, regardless of the injury severity, to seek immediate medical advice."

15.1.13 The relevance of this information is that UK police forces have long understood about the risks of head injury management and early identification of potential head injuries. A reasonable Custody Sergeant will not accept a detainee at a custody unit if they are suspected of having a head injury, as the custody health care professional (HCP) is likely to dispatch the person to hospital for an initial assessment. Road traffic collisions have long been a risk factor for consideration of head injuries, and a reasonable Custody Sergeant will want a detainee who has been involved in an airbag deployment to be medically assessed either by an ambulance crew at scene or at a hospital, before accepting them at custody.

15.1.14 In this incident both PC Short and Mr Bayoh must be considered for head injuries and appropriate management.

15.2 Please categorise Mr Bayoh's offender behaviour at the time of the assault

15.2.1 At the time of punching PC Short to her head, whilst she is running away from him, this would be the highest level of offender profile behaviour at level 6 - serious/aggravated resistance.

15.2.2 Considerations would include the physical demographics between a large muscular male and small female. The impact of the force to her head, knocking her to the ground would compare to a high energy impact, as per NICE head injury management guidance.

15.2.3 Such a blow to PC Short could cause serious or fatal injuries. An aggravating factor would be that she was running away from him at the time of the punch.

15.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

15.3.1 This punch and knock to the floor would be, in my opinion, a level 6 attack on the officer. It would cause a reasonable officer to believe that baton strikes are reasonable in their defence. The assessment of risk would indicate a high level of risk to officers attempting to stop a continued attack upon them. It demonstrated Mr Bayoh has the ability and intent to harm officer(s).

15.4 What level of response was appropriate?

15.4.1 Baton strikes to a primary or secondary target area were reasonable**.** Officers should consider if a person has the opportunity, means, ability and intent. If so, they present a high risk.

15.4.2 Physical tactics were also reasonable to consider such as pushing Mr Bayoh away from PC Short, if he remained at the scene.

15.4.3 A strike to the head by the officer is not a reasonable officer response, unless the risk of not doing so outweighs the risk of doing so. A baton strike to the head can cause fatal injuries, as the baton is likely to impart more energy into the brain than a fist. The officer must be aware of the medical implications of striking various target areas on the subject in order to justify their intended actions.

15.4.4 To continue striking the officer whilst on the ground, would increase the likelihood of serious or fatal injury.

15.4.5 One punch to the back of the officer's head, knocking her to the ground, would justify an immediate strike by the officer to a primary or secondary target area for her defence. If Mr Bayoh continued in the aggravated attack of the officer this would increase the risk to her for the officer to consider his response.

15.4.6 At this point I am asked to consider the scenario without a stomp being used by Mr Bayoh against PC Short. PC Tomlinson recorded in his PIRC statement[135]:

15.4.6.1 "I struck him with my baton once to his head. It was to the left hand side to his head, diagonally from the back of the head to his jaw."

15.4.6.2 "I think I hit him again which was about 2 or 3 times in total to the head area."

15.4.6.3 "I thought he was going to attack me again so I struck him 2 or 3 times with my baton to his arms."

15.4.7 In his Public Inquiry statement[136] PC Tomlinson recorded:

15.4.7.1 "I issued more than one strike to Mr Bayoh's head area."

15.4.7.2 "The objective was to stop Mr Bayoh killing PC Short."

15.4.7.3 "as soon as I achieved this objective and Mr Bayoh stopped his actions towards PC Short I did not strike this body area again."

15.4.8 The multiple strikes to Mr Bayoh's head is now a high-risk factor which requires urgent notification to the ACR for ambulance attendance. The strike(s) to PC Short also require urgent notification to the ACR for ambulance attendance.

15.4.9 Each strike with the baton is a separate use of force, which requires individual justification.

15.5 What tactical options were open to a reasonable officer?

15.5.1 An officer seeing a colleague being struck to the ground would be expected to act in their defence, and their own defence. Options would include:

---

[135] PIRC-00263
[136] SBPI-00043

15.5.1.1 Pushing the subject away from the officer and placing themselves between the two.

15.5.1.2 Striking the subject, especially if the subject is still appearing to be a threat to the officer on the ground. The strike may be by officer's limb or baton.

15.6 Please identify all factors relevant and material to your assessment of the option(s) available

15.6.1 Relevant factors would include:

15.6.1.1 Mr Bayoh's perceived opportunity, means, ability and intent to continue with an attack against officers;

15.6.1.2 The number of officers available to deliver a tactical response;

15.6.1.3 The capability of the officer(s) subject to energy levels, and remaining PPE; and

15.6.1.4 Availability of additional resources.

15.7 What option(s) would a reasonable officer have chosen? Why?

15.7.1 I am of the opinion the reasonable officer would have used their baton to strike Mr Bayoh after he had punched the officer to the ground, especially based upon the fact now three of the four officers were incapacitated to various levels. I am of the opinion the reasonable officer would have attempted to strike the primary target area rather than the head. However, if they believed that Mr Bayoh had intent to kill an officer the head area could be a viable option. Due to the risks associated with any head strike it must be justifiable and the control measure would be to seek urgent medical attention. Any strike to the head is significant, and every strike to the head must be justified as necessary, reasonable and proportionate to the level of threat. Multiple strikes to the head will significantly increase the risk and will require an urgent medical intervention as the control measure. I have never struck a person to the head within my police service, but have on one occasion struck across the chest with my baton when primary target areas failed to prevent the subject advancing towards me.

15.8 On balance of probabilities, had that option been selected, what difference might that choice have made?

15.8.1 The baton strike was selected by PC Tomlinson. However, the strike was to the head, which is a red area when other primary and secondary target areas had not been attempted. PC Tomlinson believes he struck Mr Bayoh's head 3 or 4 times in total with his baton. A primary or other secondary target area may not have prevented Mr Bayoh attacking PC Short, and were not attempted. Any baton strike to the head should be treated as a medical emergency and the ACR should be informed as soon as practicable for an ambulance to be requested. Medical attention must be arranged as soon as practicable.

15.9 Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer

15.9.1 As above, the strikes to the head carry a significant risk of harm to Mr Bayoh, who has already shown behaviours which could be attributed to vulnerability. PC Tomlinson then recorded[137] that "I thought he was going to attack me again so I struck him 2 or 3 times with my baton to his arms. At that time I thought he was trying to kill me now after killing Nicole". I am of the opinion that a reasonable officer in this position would strike Mr Bayoh again, especially to the arms. A reasonable officer would understand the significance of administering additional head strikes.

[137] PIRC-00263

16. Question 4. Hypothesis 2: punch to back of head, followed by stamp(s), as demonstrated by Constables Walker and Tomlinson in their evidence

- **16.2 Please categorise Mr Bayoh's offender behaviour at the time of the assault**
- **16.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **16.4 What level of response was appropriate?**
- **16.5 What tactical options were open to a reasonable officer?**
- **16.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **16.7 What option(s) would a reasonable officer have chosen?**
- **Why?**
- **16.8 On balance of probabilities, had that option been selected, what difference might that choice have made?**
- **16.9 Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer**

16.1 General information

16.1.1 As above[138] officers are trained to understand the head area is a 'red' area for medical risks.

16.1.2 A punch to the head, knocking a person to the ground can be fatal or cause significant disabilities. Trauma to the spinal cord can also cause death or significant disabilities. If a person receives both elements of trauma through an attack, it is reasonable to believe the person may be killed or have suffered significant injury. This

[138] See Section 15 of this Report.

would be a medical emergency for the assaulted person, and the ACR should be informed as soon as practicable for an ambulance to attend.

16.1.3 Officers are taught that the spine is colour-coded as 'red' for high risk. A stomp to any part of the back could send trauma through the spine, due to the size of the foot.

16.1.4 A reasonable officer would know that the head and spine are red areas, and that red areas can cause death or serious injuries. The greater the force, or the greater the repetition, the higher the risk.

16.2 Please categorise Mr Bayoh's offender behaviour at the time of the assault

16.2.1 As explained in section 15, the punch to the head would be level 6, as could be the stamp to the torso. A stamp to the torso area could still impact the spine due to the size of the foot. A punch to the head would be a significant aggravating factor for police to consider from a use of force perspective. Medical expert opinion would have to be provided by a medical professional, but from a use of force perspective we teach that the red areas mean high risk of death or disability.

16.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

16.3.1 The combination of the head punch and torso stamp would be a significant threat to life and a reasonable officer would act to protect their colleague.

16.4 What level of response was appropriate?

16.4.1 A reasonable officer response to such a level 6 offender profile, would include consideration of defensive tactics and potential lethal force. The use of the baton would be a reasonable officer response.

16.4.2 Taser would be considered a reasonable officer response, if available.

16.4.3 A police dog would be a reasonable officer response, if available.

16.4.4 PC Tomlinson stated that he believed PC Walker was slashed in the face, that he did not know PC Paton's whereabouts, and that PC Short was punched to the head and twice stamped to the torso/spine area. He stated he thought Mr Bayoh was going to kill her. The continuum of offender profile behaviour to this extreme would create a reasonable officer response of considering a baton strike to a red area such as the head, if they believed that was justified. Officers must understand the significant risk associated with any head strike.

16.5 What tactical options were open to a reasonable officer?

16.5.1 Tactical options would include:

16.5.1.1 Striking Mr Bayoh with officer body limb or baton;

16.5.1.2 Use of CS/PAVA if available, however three officers had already deployed spray with no effect;

16.5.1.3 Taser if available, which was not at scene;

16.5.1.4 Police dog if available, which was not at scene; and

16.5.1.5 Shield deployment if available, which was not at scene.

16.6 Please identify all factors relevant and material to your assessment of the option(s) available

16.6.1 Relevant factors would be based upon the behaviour to date, such as:

16.6.1.1 Mr Bayoh is alleged to have both struck the officer in the head and stamped upon her torso. The combination of both actions could reasonably be believed to cause significant injury, or death to PC Short;

16.6.1.2 PC Tomlinson now believes that Mr Bayoh has incapacitated three officers, and he is now the only officer currently at the scene, without any CS left;

16.6.1.3 PC Tomlinson does not know the estimated time of arrival for specialist resources;

16.6.1.4 Non-specialist resources in attendance could also be injured;

16.6.1.5 Mr Bayoh has displayed warning signs which officers are trained to consider such as extreme strength and CS/PAVA having no effect;

16.6.1.6 If Mr Bayoh was willing to leave, permit his exit from the scene; and

16.6.1.7 The need to notify ACR of the situation.

16.7 What option(s) would a reasonable officer have chosen? Why?

16.7.1 The reasonable officer would attempt to protect their colleagues, and themselves from the risk of significant harm from Mr Bayoh, whilst also attempting to minimise injury to him.

16.7.2 Possession of a knife has not yet been discounted and it would be reasonable to believe that specialist officers were required to deal with Mr Bayoh.

16.7.3 The ACR would be required to manage specialist patrols attending to deal with Mr Bayoh.

16.7.4 The reasonable officer needs to provide immediate first aid to their three colleagues and summon medical and other officer assistance. PC Tomlinson currently has grounds to request an ambulance for PC Walker, PC Paton and PC Short in addition to Mr Bayoh, A total of four casualties.

16.7.5 If Mr Bayoh is unwilling to leave the location the reasonable officer will be forced to respond with defensive tactics to protect themselves until additional assistance arrives. The officer needs to be calling for dog(s) and ARV.

16.8 On balance of probabilities, had that option been selected, what difference might that choice have made?

16.8.1 Had Mr Bayoh been able to, and allowed, to leave the scene this would have displaced the risk for specialist officers to deal with, and permitted PC Tomlinson to administer first aid to his three colleagues.

16.8.2 Had specialist resources attending such as a dog or AFOs (Taser) attended it is likely Mr Bayoh could have been detained without significant restraint occurring.

16.9 Please categorise and comment on the response by Constable Tomlinson. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer

16.9.1 PC Tomlinson stated that he struck Mr Bayoh to the head several times, whilst Mr Bayoh was stamping on PC Short. PC Tomlinson stated he believed that Mr Bayoh had killed PC Short. He also believed that Mr Bayoh had slashed the other officer. PC Tomlinson recorded[139]: “At that time I thought he was trying to kill me now after killing Nicole”. Based upon these facts, if PC Tomlinson honestly believed Mr Bayoh had slashed PC Walker, killed PC Short, and was now about to kill him, I am of the opinion that a reasonable officer would have considered the same, or similar, tactics for self-defence of their own life. Head strikes could be justified in this circumstance, if after each one the attack was continuing. Upon being able to do so, medical attention must still be summoned.

[139] PIRC-00263

17 Question 5. Restraint - taking Mr Bayoh to the ground

- **17.2 Please categorise Mr Bayoh's offender behaviour at the time he was taken to the ground**
- **17.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **17.4 What level of response was appropriate?**
- **17.5 What tactical options were open to a reasonable officer?**
- **17.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **17.7 What option(s) would a reasonable officer have chosen? Why?**
- **17.8 On balance of probabilities, had that option been selected, what difference might that choice have made?**
- **17.9 Please categorise and comment on the response by Constable Walker. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer**
- **17.10 Please comment on the manner in which Constable Walker took Mr Bayoh to the ground (i) on the hypothesis that he "shoulder charged" Mr Bayoh to the ground and (ii) on the hypothesis that he took Mr Bayoh to the ground in a "bear hug"**

17.1 The history of use of force and restraint.

17.1.1 I first completed my police officer safety training (OST) in February 1990, and continued with police annual refreshers until I left in 2013. One of my roles within police training was as head of a specialist training team which covered custody training, all use of force and first aid. Police baton use came to the UK from America along with the American materials which included the Monadnock baton chart for body trauma. The majority of my training team were civilian trainers so I was heavily involved in their courses to bring the police context to the techniques they were delivering.

17.1.2. Reference documents relevant to this section include:

17.1.2.1 Police Scotland OST Manual[140];

17.1.2.2 Use of Force SOP[141];

17.1.2.3 Police Scotland OST powerpoint[142];

17.1.2.4 Care and Welfare of Persons in Police Custody SOP[143];

17.1.2.5 Independent Advisory Panel common principles for safer restraint: and

17.1.2.6 The National Decision Making Model (NDM)[144].

17.1.3 Throughout the UK secure sectors of policing, prisons, and secure mental health services, common principles and techniques are taught, and information is shared as part of the UK's safer custody process with the National Preventive Mechanism (NPM) which requires the sharing of lessons learned.

17.1.4 Since the adoption of 'safer custody' by the UK secure sectors, initially from 2002, an emphasis has been placed upon 'safer restraints'. Use of force/restraint is not to be assessed in isolation as a technique, but as part of a continuum for safer custody. It is part of a process, based and centred around a human rights and risk assessed approach, with appropriate safety/control measures.

17.1.5 Sectors produce manuals containing their 'approved techniques'. These techniques are medically assessed and approved for use, and staff are trained to apply the techniques in a range of circumstances, and to understand the control measures. In response to inquiries, those techniques may be reviewed and modified with additional safety instruction. Techniques throughout the UK sectors are comparable particularly in relation to ground restraint. A common technique is known as a 'relocation' or 'extraction' technique which is based around a principle of taking a violent/deranged person to the

[140] PS11538(a)
[141] PS10933
[142] PS17208
[143] PS11014; PS17915; PS17918
[144] PS13182

ground, obtaining control, then manually moving them to another location/vehicle and releasing them. UK police and prison staff are trained in this technique. It may, at times, be justified to deviate from approved techniques, due to the individual circumstances of the incident and person(s) involved.

17.1.6 In December 2003, an Inquiry[145] published a report concerning the restraint death of Mr David Bennett. This was one case which lead to a 2004 Metropolitan Police review of restraints, which was published for public access. Mr Bennett had been held in prone restraint for approximately 25 minutes with staff laying over his legs and torso. The Inquiry found that staff should have recognised Mr Bennett was in a state of collapse earlier than they did. This Inquiry considered the time within prone position and stated "We recognised that it was arbitrary to impose a specific time limit, but we concluded that the imposition of a time limit was essential in order to minimise the risk. We therefore recommend that a person should not be restrained in a prone position for more than three minutes."[146]

17.1.7 As part of the Mr Bennett Inquiry, the Royal College of Nursing (RCN) stated that: "Face-down positions were more dangerous than face-up, but said that it must not be forgotten that face-up positions could still be dangerous." [147]

17.1.8 The Police Complaints Authority in their publication "Policing Acute Behavioural Disturbance (2002)" cited that: "The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised."[148]

17.1.9 The Metropolitan Police Service (MPS) Review of 2004[149] followed the death of Roger Sylvester and others, and the issues arising from the Inquests. The review recommended that: "Officer safety training should stress that restraining a person in the

[145] Published by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority: Independent Inquiry into the Death of David Bennett
[146] Page 52 of the Independent Inquiry Report into the Death of David Bennett
[147] Page 52 of the Independent Inquiry Report into the death of David Bennett
[148] Page 7 PCA Policing Acute Behaviour Disturbance
[149] http://policeauthority.org/Metropolitan/downloads/committees/mpa/mpa-040930-11-appendix01.pdf

prone position is potentially dangerous and include appropriate techniques to re-position violent persons from the prone position as quickly as possible."[150]

17.1.10 The MPS Review of 2004 considered whether to recommend a time limit, but concluded that it was neither safe nor practicable to set one and that the prone position should be for "the minimum time necessary to achieve control". Although this Inquiry was an English Inquiry, through the UK safer custody process all sectors are encouraged to share information and learn from one another. Page 11 of the report stated: "There are no substantial differences between the Police, Prison and Health services when the specific types of holds are analysed. The Review believes, however, that lessons can be learned from the Prison Service where team leaders are employed to direct restraint teams. The role of the supervisor is to take immediate charge of the incident, monitor the health of the person being restrained and actively control the restraints being applied."

17.1.11 The MPS Review of 2004 addressed the need for a 'supervisor' to monitor the health and wellbeing and vital signs of the restrained person (as also occurs in the UK prison sectors, and recommended by the Independent Advisory Panel for safer restraint). It recommended that such a safety officer should take charge of the incident and actively control the restraints being applied by the other officers.

17.1.12 The Metropolitan Police Service established the Independent Commission on Mental Health and Policing, chaired by Lord Victor Adebowale. The report of the Commission was published in May 2013, and set out 28 recommendations.[151]

17.1.13 The Independent Advisory Panel (IAP) produced for the UK their guidance concerning common principles of safer restraint. The full criteria is listed at Appendix G of this report. This was distributed throughout the UK secure sector membership of the

---

[150] http://policeauthority.org/Metropolitan/downloads/committees/mpa/mpa-040930-11-appendix01.pdf Section 5.2

[151] https://mentalhealthpartnerships.com/resource/independent-commission-on-mental-health-and-policing-report/

NPM. This was circulated to approximately 150 organisations throughout the UK and was also published in the 5th NPM annual report 'Monitoring Places of Detention'.

17.1.14 The common principles for safer restraint include:

17.1.14.1 "Physical restraint can occasionally result in the death of the individual being restrained."

17.1.14.2 "If three or more staff are actively involved in a restraint then one of those staff must be in control of the restraint (Controller) and it must be clear at all times, to all those involved in the restraint who the Controller is."

17.1.14.3 "At the start of an episode of restraint the staff member responsible for protecting the detainee's head, neck and breathing will assume the role of Controller regardless of rank."

17.1.14.4 "The Controller will be confirming their role to colleagues as soon as possible after the start of the restraint using a designated phrase. (e.g. 'I now have control of this incident')."

17.1.14.5 "The Controller must have the authority to order the alteration or release of any of the restraint hold(s)."

17.1.14.6 "All approved restraint techniques must take into account the possibility that underlying disease(s) may render an individual more susceptible to adverse effects and possibly death."

17.1.14.7 "The vital signs (Airways, Breathing, Circulation) of the restrained individual must be assessed as soon as possible after the commencement of restraint by a member of the team nominated to do so by the Controller."

17.1.14.8 "These assessments of vital signs must be repeated frequently throughout the period of restraint and the results made known to the Controller. Medical advice must be obtained if any concerns are expressed."

17.1.15 The (Independent Police Complaints Commission) IPCC published a report[152] concerning the examination of deaths in police custody for the 11 years from 1998 to 2009. Although an England & Wales publication, it is freely available online and should be shared amongst, and available to, the NPM membership.

17.1.16 The Home Affairs Committee (HAC) Inquiry into Policing and Mental Health in May 2014[153] stated: "The fact that nearly half of police-related deaths now involve people with mental illness is evidence that policing on the ground is failing to recognise or adequately adjust to the changing nature of this policing demand."

17.1.17 The Police Scotland OST Manual[154] provided to me is their 2013 edition, along with their OST powerpoint slides[155]. I am informed that all officers involved in this incident would have been trained to these two reference documents. Neither document contains information which is new to me.

17.1.18 The Police Scotland OST powerpoint slides include the following statements:

17.1.18.1 "Use of force must be "The **minimum** amount necessary."

17.1.18.2 "The level of force used must be reasonable for the resistance exhibited by the subject."

17.1.18.3 "Other force options must have either been attempted and failed or have been considered and found to be inappropriate under the circumstances."

17.1.18.4 **"80%** of information is taken in through the **eyes."**

17.1.18.5 The 5 step positive style of tactical communication is "Ethical appeal; Reasonable appeal and explain; Personal appeal and options; Practical appeal and confirmation; Action."

17.1.18.6 "Reaction gap 4-6 feet."

---

152 https://webarchive.nationalarchives.gov.uk/ukgwa/20170914112706/http:/www.ipcc.gov.uk/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

153 https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

154 PS11538(a)

155 PS17208

17.1.18.7 "Edged weapons create distance – use cover – transmit."

17.1.18.8 "Positional asphyxia. Positional Asphyxia is likely to occur when a subject is in a position that interferes with inhalation and/or exhalation and cannot escape that position."

17.1.18.9 "Excited Delirium. A person exhibits violent behaviour in a bizarre and manic way."

17.1.19 If a person is taken to the ground as a minimum use of force for a necessary, reasonable and proportionate act, core principles exist:

17.1.19.1 They should be taken to the ground as safely as possible, with staff conscious that the fall to the ground could result in injury;

17.1.19.2 Prone position should be for as short a time as possible;

17.1.19.3 The detained person is constantly monitored for vital signs such as airway, breathing and circulation;

17.1.19.4 An officer assumes the role of Controller to co-ordinate the manual handling of the detainee;

17.1.19.5 An officer assumes the role of safety officer. This may have to be a dual role subject to available numbers;

17.1.19.6 The detainee is removed from prone/supine as soon as possible into a side position;

17.1.19.7 From side position, the person is moved to seated and then standing positions;

17.1.19.8 The need for medical assistance is constantly assessed;

17.1.19.9 Any lack of consciousness should be treated as a medical emergency, urgent medical attention requested and all restraints removed. Initial first aid provided and life saving techniques such as CPR or choking protocols administered;

17.1.19.10 Suspicion of acute behaviour disturbance/excited delirium must be treated as a medical emergency;

17.1.19.11 The need to restrain must be continuously assessed and being necessary, reasonable and proportionate;

17.1.19.12 A person search should be conducted as soon as possible, once secured and safe. If necessary whilst still in prone/supine, the officer should search systematically and with speed to not unnecessarily delay removing from prone/supine;

17.1.19.13 No pressure should be exerted through the torso, head or neck; Pressure to any part of the torso can restrict the working of the diaphragm and reduce breathing efficiency. An exception is force to the shoulder blade area to assist with initial control;

17.1.19.14 Officers are informed regarding 'Traumatic Asphyxia' which is produced by a sudden increase in venous pressure and associated with the use of 'fastraps' restraints being applied to the subject; and

17.1.19.15 Capillary refill checks are standard safety checks to conduct on persons who are hand cuffed and/or restrained with straps.

17.1.20 The Police Scotland OST manual states:

17.1.20.1 "Where extreme and excessive force is applied, or where the application of force is maintained for longer than is necessary, to achieve a lawful aim that may amount to torture etc."[156]

17.1.20.2 "In relation to all the above articles, the use of force must be based on an honestly held belief that it is absolutely necessary; which is perceived for good reasons to be valid at the time."

17.1.20.3 "The level of force must be appropriate to the degree of resistance exhibited by the subject."[157]

17.1.20.4 "Other force options must have either been attempted and failed, or have been considered and found to be inappropriate under the circumstances."

17.1.20.5 "Police officers use force to establish control of people and situations for the following reasons:

---

[156] Module 1, Section 2
[157] Module 1, Section 3

- Self-defence/defence of others
- To effect a lawful arrest
- To prevent the escape of a prisoner
- To prevent a crime being committed
- To preserve order.

Whatever the use of force, the officer will require to answer: "Could the officer have achieved the same lawful objective by using a lower force option?"

17.1.20.6 "Two officers confronted with the same set of circumstances may react differently. They may select different force options each of which they perceived to be appropriate and reasonable for them. It is for each officer to justify their individual course of action. The Police Scotland National Decision Model should be considered at all times."

17.1.20.7 "Officers carry out subjective assessments of hazards during high-risk real-time incidents, and take appropriate and immediate actions to manage the hazards and control the risks."

17.1.20.8 "Whilst the officer requires to be behaving in a rational and effective manner, the heightening of psychological and physical states may hinder the process."[158]

17.1.20.9 "I will not encourage, instigate or tolerate any act of torture or inhumane or degrading treatment under any circumstance nor will I stand by and allow others to do the same. I understand that the humane treatment of prisoners is an essential element of policing and that the dignity of all those I am trusted to care for remains my responsibility. (Article 3)."[159]

17.1.20.10 "Officers should recognise the following symptoms and be prepared to administer emergency first aid: • Body position restricted to prone, face-down • Cyanosis (bluish discolouration of the extremities) • Gurgling / gasping sounds •

[158] Module 1, Section 6
[159] Module 1, Section 10

An active subject suddenly changes to passive or loud and violent to quiet and tranquil • Panic • Verbalising that they cannot breathe."[160]

17.1.20.11 "When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the physiological response to that is accelerated breathing."

17.1.20.12 "When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface."

17.1.20.13 "The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia."

17.1.20.14 "Officers are encouraged to remove the subject from the prone position as soon as possible following restraint. The subject can then breathe without restriction and the officer can still carry out search procedures before executing the safe get-up technique."

17.1.20.15 "Any subject exhibiting symptoms of excited delirium should be treated as a MEDICAL EMERGENCY and be assessed immediately at a hospital."[161]

17.1.20.16 Regarding pain compliance techniques "The pain caused by the restraint should discourage the subject's resistance. It must, however, be recognised that the tolerance to pain can be raised by alcohol, drugs, mental conditions and indeed the mindset of the subject concerned."[162]

17.1.20.17 "Pain can also over stimulate the brain and when the body is subjected to high levels of pain, the subject may experience difficulty in hearing. It is therefore vitally important for officers to communicate clearly and concisely throughout the confrontation in order to gain compliance."

---

[160] Module 1, Section 11
[161] Module 1, Section 12
[162] Module 2, Section 1

17.1.20.18 "MOTOR DYSFUNCTION. This is caused when certain motor nerve points in the body are over stimulated. This can result in short term muscle impairment and render a limb useless for a few seconds. When a muscle or soft tissue area is struck as opposed to bone, injury potential is reduced. Motor dysfunction does not rely on the subject's tolerance to pain. The stunning effect of striking a muscle mass overwhelms the senses, e.g. a strike to a thigh will cause a dead leg for a few seconds allowing the officer time to re-assess their options."

17.1.20.19 "Time or distance is a safety barrier and should only be reduced at the discretion of the officer, never at the subject(s). When dealing with a subject a working reactionary gap of between 4 to 6 feet should be sufficient to allow effective communication and at the same time allow the officer to observe the subject's actions and demeanour. This gap could be increased dependent on the information available to the officer."[163]

17.1.20.20 "As well as trying to maintain the reactionary gap, officers should be aware of tactical positioning in relation to a subject and should realise the dangers of standing directly in front of a subject."

17.1.20.21 "When two officers are dealing with a subject they should adopt the contact and cover principle. This enables one officer to take control, whilst the other officer takes up observations from a safe distance."[164]

17.1.21 OST utilises what is known as a 'flinch response' or 'natural response'. These are the responses of the mind and body to sudden unexpected stimulus. They are automatic and, in many cases, predictable. For example, if a vehicle backfires unexpectedly then most people nearby would exhibit the same initial reaction or involuntary reflex action. These natural responses are unavoidable, but training can assist to convert these reactions into tactical actions. For example if a person suddenly lashes out at an officer they should naturally and instinctively raise their arms upwards to block the strike.

[163] Module 2, Section 2
[164] Module 2, Section 2

17.1.22 Police officers are not medically trained, and as discussed elsewhere in this report they receive various levels of first aid training. They are taught what to look for regarding warning signs/factors. If such signs or factors are present then they should obtain medical assistance as soon as reasonably practicable.

17.1.23 Police Scotland formed in 2013 and as part of that formation teams were reviewing what materials were being used within the Scotland police forces to consolidate into one national publication. PC Stephen Boyd provided information to both PIRC[165] and the Inquiry[166] stating he had been involved in the collation of materials which also included him obtaining materials from the College of Policing and the Metropolitan Police Service. This means the English materials, principles and practices which I refer to were provided to Police Scotland.

17.1.24 The history of first aid training within the police service has regularly been reviewed following death in custody inquiries, investigations and inquests. Common themes include:

17.1.24.1 Positional asphyxia;
17.1.24.2 Excited delirium;
17.1.24.3 Drug/alcohol intoxication;
17.1.24.4 Head injuries;
17.1.24.5 When to commence CPR; and
17.1.25.6 Vital signs.

17.1.25 The first edition of the 2006 Safer Detention and Custody of Persons in Police Custody was produced for the mandatory adoption of ‘safer custody’ as part of the UK’s compliance with the European standards. This publication was produced by the Association of Chief Police Officers (ACPO), Home Office and the National Centre for

[165] PIRC-00497
[166] SBPI-00116

Policing Excellence. This was updated in 2012 and is available online[167]. The document refers to the ACPO police First Aid Learning Programme (FALP). The various roles within policing were assessed to establish the minimum recommended first aid training required. Operational Constables who met with the public were recommended to have a minimum of FALP level 2 which was equivalent to the civilian 1 full day emergency first aid at work course. The course content was specifically itemized to include:

17.1.25.1 Primary and secondary surveys of casualties;
17.1.25.2 How to check airway and breathing;
17.1.25.3 How to observe and monitor a casualty;
17.1.25.4 The chain of survival;
17.1.25.5 DR ABC;
17.1.25.6 Performing CPR for a casualty who is not breathing normally; and
17.1.25.7 Spinal injuries.

17.1.26 FALP level 3 is the equivalent to the civilian 3 day first aid at work course and includes all of the FALP 2 content plus additionally covers conditions including:

17.1.26.1 Head injuries; and
17.1.26.2 Acute Behavioural Disorder and Excited Delirium.

17.1.27 I will explain later in my report the difference between 'not breathing' and 'not breathing normally'. As per the FALP objectives officers should be taught the 'not breathing normally' first aid principles and practices.

17.1.28 I am aware from the training records that PC Craig Walker completed the 3 day first aid at work training courses, but I have not viewed the training materials concerning

167 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf

his course objectives and if he was trained concerning breathing/not breathing or breathing normally/ not normal.

17.1.29 The other officers appear to have received a basic Police Scotland first aid input for life saving, not the 1 day emergency first aid at work course. At this time I have not had sight of their first aid training materials.

17.1.30 First aid training should teach all officers how to conduct a primary and secondary survey which includes the DR ABC casualty assessment. This means:

17.1.30.1 Danger- Are there any obvious dangers present for either officers or the casualty? This could include a physical position which reduces breathing capability.

17.1.30.2 Response - The response test is referred to as AVPU[168]. Is the casualty alert? Do they respond to voice commands? Do they respond to induced pain stimulus? Are they unresponsive?

17.1.30.3 Airway - Is the airway in a suitable position? Place one hand on the head and one hand on the chin and move the head slightly backwards to clear the airway. Is there a physical obstruction requiring a choking response?

17.1.30.4 Breathing - Is breathing normal or not normal? Moaning or snoring noises are not normal breathing. Loud or irregular noise is not normal breathing. The breathing check should take up to 10 seconds maximum and establish 2-3 normal breaths during this time.

17.1.30.5 Circulation - If breathing is not normal commence CPR to assist with circulation. Call 999.

17.1.31 In my opinion, it is essential that any person who is trained to conduct restraint fully understands the safety control measures for DR ABC so they are able to effectively monitor a casualty throughout a period of restraint.

---

[168] AVPU scale – Alert, Voice, Pain, Unresponsive.

17.1.32 Prone position is also covered in section 18 of this report. Prone position has previously been interpreted throughout the secure sectors differently. The basic principle is that a 'prone position' means the front of the body (naval to throat) is towards the ground and 'supine position' means the back is towards the ground. It is ultimately concerning how breathing is impacted through physical and anatomical conditions.

17.1.33 The Police Scotland OST Manual states[169]: "When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface". The phrase 'pressed against a surface' is the relevant factor.

17.1.34 Within OST and first aid training, officers should learn how the body works for breathing. I am not a medical professional but as a use of force trainer and a first aid trainer, I understand the basic anatomy and physiology that a body needs to take in oxygen and expel carbon dioxide. For this to occur we have the respiratory system. This system is made up of the nose, mouth, throat, windpipe and lungs. The diaphragm is the main breathing muscle of the body which sits below the rib cage and above the stomach. In order for the diaphragm to work it needs other muscles to be able to work. These other muscles are called 'accessory muscles' and are the muscles surrounding the ribs, the abdominal muscles and the muscles within the neck and shoulders. If any part of this system is impacted, this will impact upon breathing capability and efficiency.

17.1.35 When the diaphragm and accessory muscles contract, the chest expands and the body inhales air through the nose and mouth, which travels to the lungs. As the muscles then relax, the system exhales and removes the carbon dioxide out of the body.

[169] Module 1 Section 11 OST Manual

17.1.36 The inhaled oxygen then enters the blood stream and is taken throughout the body to keep the body oxygenated.

17.1.37 The brain is the 'hard drive' of the body and controls the functions. The brain controls and regulates the breathing process. Any head injury can impede the respiratory system due to brain trauma. This is another reason why potential head injuries are a high risk for police custody detainees, and why a reasonable Custody Sergeant will send a suspected head injury to hospital for assessment.

17.1.38 'Red' areas taught within the OST training[170]include:

17.1.38.1 Head;

17.1.38.2 Spine;

17.1.38.3 Neck; and

17.1.38.4 Solar plexus (sits behind the stomach in the abdomen, alongside the diaphragm. Roughly midway between the naval and the heart)

17.1.39 Police should aim to prevent pressure to the body from just above the naval to the throat, in order to not impede the breathing function. This applies to the front and rear of the body.

17.1.40 If a person is in a frontal position towards the ground, this is a prone position. Fully prone would be that the front of the body, from naval to throat, is at the ground, but prone would still cover compression of the solar plexus and diaphragm against the ground. An officer must also consider excess body weight and pregnancy. If a person is in full prone or partial prone, the weight of the body or pregnancy may be pushed against the solar plexus or diaphragm and impede breathing.

[170] See Appendix E

17.1.41 Positional asphyxiation is about any position, or applied force, of the body which causes any part of the respiratory function to be inefficient. Fit and healthy people, with no underlying medical condition or intoxication, can tolerate more interference than a person who has risk factors. Those risk factors would include weight, intoxication, mental ill health, head injury, asthma, sickle cell anemia/disease. I have been teaching about Sickle Cell to police officers as part of Use of Force and FALP3 custody first aid training since 2006.

17.1.42 The 2006 SDHP [171] stated: "Under normal blood conditions, there are no symptoms. Sickle cell disease has episodes called 'sickling crises'. These may be brought on by exposure to cold, infection or bodily water shortage (dehydration). Quite often they occur for no obvious reason."

17.1.43 Sickle cell is also included in civilian first aid training courses. I published an online first aid information course for education sector staff in 2020 concerning Sickle Cell which was CPD certified. Factors to consider concerning sickle cell include:

17.1.43.1 Sickle Cell is a hereditary condition affecting haemoglobin contained within red blood cells;

17.1.43.2 A person with sickle cell may experience a sickle cell crisis;

17.1.43.3 Signs and symptoms of a sickle cell crisis may include: Breathing difficulty, Reduction in oxygen saturation, high temperature, chest pain, cough, severe body pain, dehydration, weakness;

17.1.43.4 Genes associated with sickle cell are found primarily, but by no means exclusively, in people of African, Caribbean, Middle Eastern, South Asian and Mediterranean decent;

17.1.43.5 Due to low oxygenation cells can become misshaped – sickle shaped, or form long twisted rods. These cells are not as flexible and may become stuck in the blood vessels, depriving that part of the body of oxygen; and

[171] 2006 NPIA Safer Detention and Handling of Persons in Police Custody

17.1.43.6 Environmental factors which increase the likelihood of a sickle cell crisis include: strenuous exertion, stress, temperature, infections, dehydration.

'Sickle Cell and Deaths in Custody' was published in 2009 and is a 225-page book concerning the subject.[172]

17.1.44 When police officers are called to an incident where it is likely they will need to restrain potentially violent or disturbed detainees, it is important that where possible they are properly briefed on the medical condition/risks of the individual. Throughout any use of force an officer should be able to observe and monitor the person and react to any situation which may arise.

17.1.45 Close supervision of detainee's health and welfare must be maintained during periods of restraint. Individuals may react differently to restraint, especially if restrained in the prone position, or they are suffering a mental health crisis.

17.1.46 The restraint supervisor/controller must ensure that the health of the detainee is monitored and that the degree of restraint being applied is reasonable. The monitoring is the DR ABC of first aid.

17.1.47 The 2012 College of Policing SDHP guidance[173], section 4.3.1[174] states: "When a detainee is restrained in a prone position for any length of time, one team member should be responsible for protecting and supporting the head and neck. That person should lead the team through the physical intervention process and ensure that the airway and breathing are not compromised and that vital signs are monitored. Prolonged restraint and struggling can, particularly when the lungs are being squeezed while empty, result in

---

[172] ISBN 18617711150 published by Whiting & Birch Ltd, Forest Hill, London.

[173] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf

[174] Page 57

exhaustion. This can be without the detainee being aware of it and can lead to sudden death."

17.1.48 Section 4.4[175] positional asphyxia states: "There is a risk of positional asphyxia when restraining a person. The prone position should be avoided if at all possible, or the period for which it is used minimised. It should be recognised that there is an increased risk of causing positional asphyxia when restraining children or small adults. Body weight should not be used on the upper body to hold down the detainee."

17.1.49 "Factors that can contribute towards a death during restraint include situations where:

• The body position of a person results in a partial or complete obstruction of the airway and the subject is unable to escape from that position;

• Pressure is applied to the back of the neck, torso or abdomen of a person held in the prone position;

• Pressure is applied restricting the shoulder girdle or accessory muscles of respiration while the person is lying down in any position;

• The person is obese (particularly those with large stomachs and abdomens);

• The person is a child or small adult;

• The person has a heightened level of stress;

• The person may be suffering respiratory muscle failure related to earlier violent muscular activity (such as after a struggle)"

17.1.50 The Police Scotland OST manual Module 1 section 11 also covers positional asphyxia and states:

> **17.1.50.1** "Positional Asphyxia (Restraint Related Asphyxia) can occur when a subject is placed in a position which interferes with the ability to breathe. Death

[175] ibid

can occur rapidly, and it may be the case that a police officer can be found to be liable. The risk factors which contribute to the condition are:

- Subject's body position results in partial or complete airway constriction
- Alcohol or drug intoxication (the major risk factors)
- Inability to escape position
- The subject is prone
- Obesity
- Age
- Stress
- Respiratory muscle fatigue, related to prior violent muscular activity (such as fighting with police officers)."

17.1.50.2 "Officers should recognise the following symptoms and be prepared to administer emergency first aid:

- Body position restricted to prone, face-down
- Cyanosis (bluish discolouration of the extremities)
- Gurgling / gasping sounds
- An active subject suddenly changes to passive or loud and violent to quiet and tranquil
- Panic
- Verbalising that they cannot breathe."

17.1.50.3 "When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the physiological response to that is accelerated breathing. When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface."

17.1.50.4 "If the subject's hands are restrained to the rear breathing ability may be restricted. This must be considered by the officer. The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia. Officers are

encouraged to remove the subject from the prone position as soon as possible following restraint. The subject can then breathe without restriction and the officer can still carry out search procedures before executing the safe get-up technique."

17.2 Please categorise Mr Bayoh's offender behaviour at the time he was taken to the ground

17.2.1 Based upon the account of PC Walker: "I turned back to PC Paton as she was in mid-fall and shouted again "Alan, give me your fuckin baton". He then took his baton from his vest, extended it in my direction and I took it off him. I turned back towards PC Short and started running towards the male and PC Short. By this time PC Short was lying face down in the prone position on the road, close to the south pavement. The man (deceased) was on the opposite side of PC Short to me, standing at right angles to her and facing up towards me. I had a clear view of him and saw him with his right leg in a high raised position. He had his arms raised up at right angles to his body and brought his right foot down in a full force stamp down onto her lower back, the kidney area. My focus was mainly on him as I ran towards them with PC Paton's baton in my right hand. At this point, and prior to getting to him, I saw PC Tomlinson come towards him and engage with him in some way. There was a physical coming together and the man took a step back towards the pavement. I'm not sure what he did but it as enough to get him away from PC Short. I don't know if PC Tomlinson had CS or a baton out at that time. As I was getting close to him (deceased) I raised the baton high into the air in my right hand. My intention was due to the level of violence was to take a head strike. But he raised both his arms after he had turned towards me to protect his head As I was moving in towards him I had a quick change of mind as I thought the head strike would only connect with his forearms. I already had the impression that you could hit him with the baton and it would have little effect. So I just brought my left arm across my body and shoulder charged him with my left shoulder, with a fair bit of force. He (deceased) fell back towards the pavement. We both fell together into the pavement. As this happened I dropped the baton onto the ground somewhere."

17.2.2 The described offender profiled behaviour was at level 6 serious/aggravated resistance.

17.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

17.3.1 If Mr Bayoh had punched the officer to the ground and appeared to be intending to continue the attack, this would be an aggravated assault on the officer and would be level 6 since it could cause fatal injuries. At the lowest, it would be an assaultive act at level 5. The reasonable officer would at least assess this at level 5, minimum.

17.4 What level of response was appropriate?

17.4.1 The reasonable officer response to level 5 or 6 behaviour includes use of defensive strikes, both physical with their limbs and with their personal protective equipment (PPE).

17.4.2 Strikes from an officer with their limbs or batons would be an appropriate level of response; as would use of incapacitant sprays; and if available the use of Taser or a police dog.

17.5 What tactical options were open to a reasonable officer?

17.5.1 Tactical options would include officers pushing, pulling, punching, kicking, striking with baton, use of spray or Taser, taking to the ground to restrain.

17.6 Please identify all factors relevant and material to your assessment of the option(s) available

17.6.1 Factors would include the threat and risk level assessment such as opportunity, means, ability and intent to cause serious harm; the lack of capacity of officers; numbers

of officers available; vulnerabilities of officers and subject; medical implications of officers and subject.

17.7 What option(s) would a reasonable officer have chosen? Why?

17.7.1 If Mr Bayoh has punched PC Short to the head, knocking her to the ground, and stamped on her back, this could cause fatal injuries or significant harm. Officers have identified that incapacitant sprays have had no impact upon him. He is of a large and strong build. He may still be in possession of a knife. Due to the knife risk, a baton strike to the primary target area would be a reasonable officer response in order to maintain a distance between them and him.

17.7.2 To take Mr Bayoh to the ground, in close proximity, could enable him to stab an officer, if he had a knife.

17.7.3 To back off from Mr Bayoh, if he was proceeding to attack PC Short would not be a reasonable officer response. They would act in the defence of their colleague using what reasonable options were available to them. Saving their colleague is the priority, even if Mr Bayoh then escapes. Specialist resources can then be deployed to detain Mr Bayoh.

17.8 On balance of probabilities, had that option been selected, what difference might that choice have made?

17.8.1 Baton strikes may have succeeded in stopping the attack, however, in light of other factors as mentioned above, they may be unsuccessful. The primary objective would be to stop the assault on PC Short. If Mr Bayoh then escaped he could be pursued once additional, and specialist resources, were mustered.

17.8.2 An objective to detain and restrain Mr Bayoh would be a high-risk tactic for both the officers and Mr Bayoh. If officers were aware of the risk factors for ADB/ED any

restraint would need to be carefully conducted as this condition is a medical emergency and high-risk for death during restraint. However, if officers believe they are arresting Mr Bayoh for murder/attempt murder of their colleague the necessity to arrest for a serious crime is justifiable, but the arrest must still prioritise detainee wellbeing, and an ambulance be called.

17.9 Please categorise and comment on the response by Constable Walker. In particular, indicate to what extent, if any, his response differed to that of a reasonable officer

17.9.1 Shoulder charges and/or bear hugs are not taught as approved techniques. However, this does not preclude their use if the officer believes they are necessary, reasonable and proportionate in the circumstances. Such a technique would pose a high risk to an officer if Mr Bayoh was in possession of a knife.

17.9.2 PC Walker's technique would also rely upon the officer being comparable, or greater, in size and weight which would exclude many officers from considering this option.

17.9.3 At the point of the shoulder charge PC Tomlinson recorded[176]: "He turned around and took up a boxing sort of stance, with both fists clenched in at his chest. I thought he was going to attack me again so I struck him 2 or 3 times with my baton to his arms. At that time I thought he was trying to kill me now after killing Nicole. Craig Walker came in at this point and grabbed the man like a bear hug and wrestled him to the floor. Craig was trying to control his arms."

17.9.4 PC Walker recorded[177]: "Both PC Short and the man (deceased) were in view when I first saw them. She was running away from him and he was chasing after her. He

[176] PIRC-00263
[177] PIRC-00264

was about 4 feet away, very close. I turned away briefly to my right and said to PC Paton, who was still incapacitated with CS, and said "Give me your baton". He didn't react initially. I looked back to PC Short again and she was falling to the ground with him (deceased) right behind her. Both her feet was off the ground and he had his hands raised. I believed she had been pushed to the upper part of her body. I turned back to PC Paton as she was in mid-fall and shouted again "Alan, give me your fuckin baton". He then took his baton from his vest, extended it in my direction and I took it off him. I turned back towards PC Short and started running towards the male and PC Short. By this time PC Short was lying face down in the prone position on the road, close to the south pavement. The man (deceased) was on the opposite side of PC Short to me, standing at right angles to her and facing up towards me. I had a clear view of him and saw him with his right leg in a high raised position. He had his arms raised up at right angles to his body and brought his right foot down in a full force stamp down onto her lower back, the kidney area. My focus was mainly on him as I ran towards them with PC Paton's baton in my right hand. At this point, and prior to getting to him, I saw PC Tomlinson come towards him and engage with him in some way. There was a physical coming together and the man took a step back towards the pavement. I'm not sure what he did but it as enough to get him away from PC Short. I don't know if PC Tomlinson had CS or a baton out at that time. As I was getting close to him (deceased) I raised the baton high into the air in my right hand. My intention was due to the level of violence was to take a head strike. But he raised both his arms after he had turned towards me to protect his head. As I was moving in towards him I had a quick change of mind as I thought the head strike would only connect with his forearms. I already had the impression that you could hit him with the baton and it would have little effect. So I just brought my left arm across my body and shoulder charged him with my left shoulder, with a fair bit of force. He (deceased) fell back towards the pavement. We both fell together into the pavement. As this happened I dropped the baton onto the ground somewhere."

17.9.5 If PC Walker's account is correct, his response of taking Mr Bayoh to the ground would be within that of a reasonable officer, in my opinion. He adapted the technique midway due to the response of Mr Bayoh, as a natural response with his momentum.

The taking to the ground would be a lesser risk than a baton strike to the head, which he had initially intended to deliver. A baton strike to the head is a red area, and should be avoided if other tactics are available.

17.10 Please comment on the manner in which Constable Walker took Mr Bayoh to the ground (i) on the hypothesis that he "shoulder charged" Mr Bayoh to the ground and (ii) on the hypothesis that he took Mr Bayoh to the ground in a "bear hug"

17.10.1 As above, neither a shoulder charge nor bear hug is an approved technique in the Scottish Police manual. However, this does not exclude such techniques being used if the officer can justify their decision. The Police forces of England and Wales, do teach a technique which can look like a bear hug. The technique involves, for example, an officer approaching from the rear and bringing their right arm under the subject's right arm shoulder joint, whilst bringing their left arm over the top of the subject's left shoulder, with the officer's hands meeting across the sternum/breast bone. The subject is then lowered to the ground in a rear motion.

17.10.2 The shoulder charge or bear hug would be of a lower risk than a baton strike to the head.

18 Question 6. Restraint: position of Sheku Bayoh; duration; number of officers involved; use (and position) of force and bodyweight applied to Sheku Bayoh

Question 6 Hypothesis 1: prone restraint

- **18.2 Please categorise Mr Bayoh's offender behaviour during the restraint**
- **18.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **18.4 What level of response was appropriate?**
- **18.5 What tactical options were open to the officers involved in the restraint (i) initially, and (ii) as the restraint progressed?**
- **18.6 Please identify all factors relevant and material to your assessment of the option(s) available**
- **18.7 What option(s) would a reasonable officer have chosen? Why?**
- **18.8 On balance of probabilities, what difference might the choice of that tactical option(s) have made?**
- **18.9 Please categorise and comment on the response by the officers. In particular, indicate to what extent, if any, their response differed to that of a reasonable officer or officers**

18.1 General information

18.1.1 Relevant guidance concerning restraint includes:

18.1.1.1 Police Scotland OST Manual[178];

18.1.1.2 Police Scotland OST Powerpoint[179];

18.1.1.3 National Decision Model[180];

---

[178] PS11538(a)
[179] PS17208
[180] PS13182

18.1.1.4 Care and Welfare of Persons in Police Custody SOP[181]; and

18.1.1.5 Use of Force SOP[182].

18.1.2 Prone restraint: In addition to information within this report in previous responses, prone position is where the person is fully or partially on their front torso, commonly laying chest down to the ground. It is a position which enables officers to, theoretically, quickly gain control of a person. A common misconception is that prone is only if the face is facing into the ground. Regardless of whether the face is face down or sideways, if the chest is fully against the ground, this is a full prone position. Stomach only is still a prone position. All restraint carries risks. The cause of the agitation may in itself be fatal if ignored. Restraint itself may endanger life, especially if: undiagnosed medical conditions are present; the medical conditions causing the agitation may put the subject at greater risk when restrained; the main acute risks of restraint relate to associated difficulties in breathing.

18.1.3 Once a detainee is handcuffed, do not continue to hold them in prone unnecessarily. They should be moved onto their side or into a sitting, kneeling or standing position as soon as it is safe to do so. They may continue to kick out, however officers must get them off their stomach in some way or other as soon as they can, at least into a side laying position.

18.1.4 If a detainee continues to be extremely violent in spite of the use of handcuffs, sprays or batons, such bizarre, exhaustive and persistent violent resistance is a classic indication of a severe brain agitation case. The officer must monitor them carefully, treating them as a medical emergency as they could collapse and die at any time. Control should be informed for immediate ambulance attendance.

[181] PS11014; PS17915; PS17918
[182] PS10933

18.1.5 Being restrained in prone and handcuffed behind their back increases risk. It should be known that obesity, alcohol and drugs also increase the risk further by restricting the diaphragm and lung function.

18.1.6 The Police Scotland Officer Safety Training Manual is explained at chapter 7 of this report. It makes the following statements:

18.1.6.1 "MEDICAL CONDITIONS AND CONSIDERATIONS Two specific medical conditions, namely, Positional Asphyxia (Restraint Related Asphyxia) and Excited Delirium must be recognised by police officers when dealing with a subject."

18.1.6.2 "Positional Asphyxia (Restraint Related Asphyxia) can occur when a subject is placed in a position which interferes with the ability to breathe. Death can occur rapidly, and it may be the case that a police officer can be found to be liable."

18.1.6.3 **"**The risk factors which contribute to the condition are:

- Subject's body position results in partial or complete airway constriction
- Alcohol or drug intoxication (the major risk factors)
- Inability to escape position
- The subject is prone
- Obesity
- Age
- Stress
- Respiratory muscle fatigue, related to prior violent muscular activity (such as fighting with police officers)."

18.1.6.4 **"**Officers should recognise the following symptoms and be prepared to administer emergency first aid:

- Body position restricted to prone, face-down
- Cyanosis (bluish discolouration of the extremities)
- Gurgling / gasping sounds
- An active subject suddenly changes to passive or loud and violent to quiet and tranquil

- Panic
- Verbalising that they cannot breathe."

18.1.6.5 **"**When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the physiological response to that is accelerated breathing."

18.1.6.6 **"**When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface. If the subject's hands are restrained to the rear breathing ability may be restricted. This must be considered by the officer."

18.1.6.7 **"**The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia"

18.1.6.8 **"**Officers are encouraged to remove the subject from the prone position as soon as possible following restraint. The subject can then breathe without restriction and the officer can still carry out search procedures before executing the safe get-up technique"

18.1.7 Research demonstrates that when more than three officers are involved in a restraint, the risk to the detainee increases.[183]

18.1.8 The role of the controller and safety officer is an important one. Ideally these are two separate officers, but the role can be combined if need be. They are responsible for co-ordination of the restraint and the safety of the detainee and officers. As a Sergeant, particularly as a Custody Sergeant, I have acted as the safety officer/supervisor on numerous occasions. This involves calming the situation and coordinating all movements to prevent officers from being counterproductive with one another. Safety is the priority,

[183] The UK Independent Advisory Panel and the 2004 Metropolitan Police review

and the detainee needs to be gained control of and moved into a side/lateral position as soon as possible. Vital signs of the detainee need to be assessed as soon as possible after the commencement of the restraint, and these must be checked regularly, see DR ABC earlier in the report.

18.1.9 At 07:21:38 when PC Smith transmits “male secure on the ground” this should also be a request for ambulance attendance for Mr Bayoh to obtain medical advice at scene, if they are still at scene when the ambulance arrives. This would be due to the severity of Mr Bayoh’s behaviour indicating the possibility of a medical emergency. Officers should also be seeking to get him out of prone position as soon as possible, onto his side. Due to the baton strikes to the head he will need to be medically assessed prior to a reasonable Custody Sergeant accepting his detention.

18.1.10 At 07:22:24 when PC Walker transmits “male in cuffs still struggling” this indicates he is cuffed and has been secured on the ground for approximately 50 seconds. Officers should be focused upon taking weight off Mr Bayoh’s body, and removing him from prone. The safety officer should be assessing vital signs and verbal communication should be focusing upon trying to calm Mr Bayoh.

18.1.11 If a detainee is cuffed and Velcro straps are used on the legs, it is feasible for all officers to remove physical weight from the person, other than acting as an anchor for them to maintain a side position. This keeps the detainee out of prone and removes officer body weight.

18.1.12 Pressure to the spinal cord and solar plexus area must be avoided due to the risk this can present.

18.1.13 The 2013 MIND report ‘Mental health crisis care: physical restraint in crisis’ states:[184] “Face down physical restraint is a life-threatening form of physical restraint because of the severe impact it can have on breathing. It is a disproportionate and

[184] https://www.mind.org.uk/media-a/4378/physical_restraint_final_web_version.pdf

dangerous response to someone's behaviour when they are in a mental health crisis. Face down physical restraint has no place in healthcare settings and there must be an immediate end to its use."[185] Police officers should be aware of this information as they are sometimes called to assist in mental health clinical settings. As the mental health sector is also a part of the UK safer custody sector, this information is transferable to take into consideration.

18.1.14 For the purpose of applying limb restraints such as fastraps (also referred to as a limb restraint system, LRS) the following training principles are provided in Module 4 of the Police Scotland OST manual:

> **18.1.14.1** "Fastraps are a limb restraint system. The term "limb restraint" indicates a device that is designed and used to restrict the range of movement of the legs. Application should prevent a subject from kicking and allow for safe transportation of the subject in a vehicle."
> **18.1.14.2** "The LRS should be applied to a subject only when the officer perceives it to be absolutely necessary in defence of themselves or others."
> **18.1.14.3** "The LRS is made of "Velcro.""
> **18.1.14.4** "The subject should be controlled before applying the LRS."
> **18.1.14.5** "The LRS is a supplement to the use of handcuffs and is primarily intended for use on the legs when a subject has been taken to the ground."
> **18.1.14.6** "Officers should ensure that the subject on the ground is in the prone" and that the "handcuffs are applied."
> **18.1.14.7** "The LRS should be applied to the following sites: ABOVE KNEES In a position just above the knee joints to control the subject's upper legs. ANKLES In a position at the subject's ankles (crossed or uncrossed) in a "loop" or in a "figure of eight", encompassing the feet and ankles. The above LRS positioning will depend on the circumstances the officers are faced with."

---

[185] Page 2

[redacted]

18.1.14.10 "Following application of the LRS, an officer must not leave the subject unaccompanied • The subject should be moved from the prone position as soon as practicable. Once control is established and the subject is compliant, the subject should be positioned on their side • Officers must maintain a high level of awareness regarding positional asphyxia and excited delirium."

18.1.14.11 "When applying LRS, officers should be aware of the condition 'Traumatic Asphyxia'. Traumatic Asphyxia is produced by a sudden increase in venous pressure. This is common in those who have been hanged and occurs occasionally with crush injuries. As with Positional Asphyxia, officers should be aware of the recognition features and the relief and treatment from asphyxia related conditions. • Officers should consider loosening or removing the LRS if the subject shows signs of medical distress • Officers must have constant visual contact with the subject • Officers must continue to monitor the subject until the LRS is removed • Officers should not apply the device over injured limbs or over areas of skin injury unless absolutely necessary • Officers should continue to monitor the subject throughout arrest and control procedures and must fully brief the Duty Officer regarding restraint techniques and equipment on arrival of the subject at the custody suite."

18.1.14.12 "Whenever a subject is lifted and moved with LRS applied, officers should always maintain control of the subject. This is to safeguard the subject against injury from falls or trips, or to prevent them from causing deliberate self-harm • The LRS should be formally checked after 20 minutes. If the subject has lost sensation in the limbs the officer should consider adjusting or removing the LRS."

[redacted]

18.1.14.15 "MEDICAL IMPLICATIONS Officers should refer to the guidance within the rigid handcuff section of this manual in order to have full awareness of the medical implications of applying temporary restraining devices. All custody areas should be issued with safety cutters. Operational officers should also have access to safety cutters." The OST manual for England and Wales is comparable for limb restraints. Additional points of note include: "In addition the limb restraints can be used to temporarily restrain the arms of subjects where it is necessary"

18.1.15 The Police Scotland OST manual includes the following guidance:

18.1.15.1 "Rigid handcuffs are a temporary restraining device and cannot be applied unless a degree of control has already been achieved."

18.1.15.2 "DOUBLE LOCKING PINS These are located on the backstrap of the handcuffs and should be engaged after handcuff application to prevent the single bar from closing further. These are engaged by depressing the pins with the appropriate section of the handcuff key."

18.1.15.3 "The officer should remove the handcuffed subject from the prone position as soon as possible to avoid the likelihood of positional/ restraint related asphyxia."

18.1.15.4 "If an officer over tightens, or fails to double lock the rigid handcuffs or leaves them on someone for an extended period of time, the subject can suffer from Handcuff Neuropathy. Handcuff Neuropathy involves damage to the subject's radial, ulna and/or median nerves which is caused by compression of the handcuffs. This nerve damage can be temporary or even permanent."

18.1.15.5 "Once both handcuffs have been applied, they should be checked for appropriate tightness. Care should be taken not to pinch the subject's skin or restrict circulation."

18.1.15.6 "The officer should place the tip of a finger between the cuff and the subject's wrist, at the radial or ulna sides. There should be a small degree of movement between the wrist and handcuff. The handcuffs should not be able to move over the styloid process towards the elbow."

18.1.15.7 "The officer should visually examine the handcuffs to ensure that they are positioned correctly and that the subject's wrists are not displaying signs of excessive tightness such as reddening or creasing of the skin."

18.1.15.8 "The officer should ask the subject if the handcuffs have been appropriately applied. The officer should respond to any complaint of the handcuffs being too tight or painful by rechecking the handcuffs utilising physical, visual and verbal checks. Once the officer is satisfied that all the checks have been completed satisfactorily, the handcuffs should be double locked."

18.1.16 Additional comments in the England & Wales OST Manual include:

18.1.16.1 ACPO guidelines for use of handcuffs is included. This is from 2009.

18.1.16.2 "Please note: officers have a duty of care to members of the public and persons within their custody and care. Actions must be reasonable in the circumstances and officers may be called upon to account for what they have done."

18.1.17 In theory, the tactical plan for restraining a violent person is to initially gain control. With use of a police dog or Taser, the subject is more likely to comply with a command to kneel or lay on the ground and offer their arms for handcuffing. The officer can then approach and handcuff the detainee to the rear. When these options are not available, manual handling by officers is required.

18.1.18 The manual handling process should be as quick and safe as possible, and commonly the detainee is taken to the ground to commence the process. This is based upon combining a prone position with handcuffing and limb restraints. Whilst in the prone position the two arms are brought to the rear, one officer on each arm, and handcuffs are applied. A third officer if present becomes the supervisor/controller and directs the handcuffing officers whilst monitoring the detainee, and communicating with them in an attempt to de-escalate and explain what is happening. If additional officers are present one takes the legs by laying over the legs. Once the legs are secured the fifth officer applies the straps. This equates to two officers at the legs, two officers at the arms and a controller at the head area. The controller ensures that no officer applies pressure through the torso and monitors the detainee using the DR ABC methodology.

18.1.19 As soon as the handcuffs and legs are secured, and the handcuffs are double locked, the controller coordinates the manual handling manoeuvre of the detainee to their side, then to seated and standing.

18.1.20 A detainee should not be kept on the ground longer than necessary, and constant observations should be conducted with regular DR ABC checks.

18.1.21 In the event of a medical emergency, all restraints should be removed and preservation of life is the priority.

18.1.22 From the various accounts concerning the ground restraint there are disputes concerning some facts. Generally:

18.1.22.1 Constables Walker, Paton, Tomlinson, McDonough, Gibson and Smith were physically involved in the restraint;

18.1.22.2 Acting Sergeant Maxwell attended the scene but did not get involved in the restraint believing there was no role for him;

18.1.22.3 No person formally performed the role of controller/supervisor/safety officer;

18.1.22.4 No agreement can be reached concerning whether Mr Bayoh was in prone, supine or side, or variations of which. I am unable to ascertain exactly what position(s) were used;

18.1.22.5 PC Paton was near the head area, and had a baton pressed down on Mr Bayoh's bicep;

18.1.22.6 PC Walker was near the torso area and applied the handcuffs;

18.1.22.7 PC Tomlinson and PC McDonough were at the leg area and applied the limb restraints;

18.1.22.8 PC Smith assisted with the limb restraints, and conducted some observations of Mr Bayoh. He considered excited delirium but discounted it and heard Mr Bayoh moaning and breathing.

18.1.23 PC Smith (OST trainer and first aider) updated control at 07:25:17 that Mr Bayoh was unconscious, was breathing, not responsive and requested an ambulance for Mr Bayoh. No CPR was commenced at this time. ACR was not informed of the suspected head injury. PC Smith was aware that CS and PAVA had been used on Mr Bayoh with no effect.

18.1.24 If the ground restraint commenced at 07:21:13 the restraint has lasted approximately 4 minutes 4 seconds, when an ambulance was requested. Officers originally reported he was secured at 07:21:38, at 25 seconds into the restraint. Once secure a detainee should be moved to a side position, with onward transfer to seated and standing.

18.1.25 If a detainee has shown no reaction to CS and PAVA, shown excessive strength, had eyes bulging out of his head, appeared intoxicated and/or mentally ill, displayed bizarre behaviour, appeared to feel no pain, been struck to the head at least 4 times with a baton, phlegm coming from the nose, been struck to the body numerous times with a baton - there is reason to believe this is a medical emergency and an ambulance is required. Should that person then become passive, non-responsive and fail the DR ABC test, CPR should be commenced. As ambulance crews follow NICE guidelines, all relevant information (especially concerning potential head injury) should be given to the ambulance control staff for initial triage and prioritising of responding crews.

18.2 Please categorise Mr Bayoh's offender behaviour during the restraint

18.2.1 Basic information during the restraint differs between officers, for example the basics of whether Mr Bayoh was in prone or supine and whether he was actively resisting or passive. I note the following officer comments concerning the restraint.

18.2.2 PC Walker recorded [186]: "When I got onto the pavement I was on my knees, while he was on his back. I made attempt to get over of the top of his shoulders and hands to get him under control. As I did this he raised his shoulders and tried to punch me with his right hand". This attempted punch would be a continuation of profiled offender behaviour level 5 – assaultive behaviour.

18.2.3 PC Tomlinson recorded [187]: "Craig Walker came in at this point and grabbed the man like a bear hug and wrestled him to the floor. Craig was trying to control his arms so I tried to get a hold of his legs, which were kicking out in the air. I struck the back of his legs at his achilles area a few times but he didn't stop and it failed to control him. I threw my baton to one side and jumped on the legs to try to control him". This would evidence profiled behaviour at level 4 for active resistance.

---

[186] PIRC-00264
[187] PIRC-00263

18.2.4 PC Paton recorded [188]: “As I started to keep my (eyes) open a bit more I became aware of Craig and other officers struggling on the ground with the guy on the opposite carriageway. The carriageway in Gallagher's direction. I was still struggling and I made my way over to Craig and the other officers on the ground.”

18.2.5 Acting Sergeant Maxwell recorded [189]: “I got out my car and I could clearly see the black male lying on the ground. He was on the south footpath, he was beyond the corsa but not as far up as the custody van. His head was towards the houses and his feet were towards the road. He was lying on his left side and he was facing me. I saw PC Alan Smith on the other side of the body as I was looking at it. He was nearer the shoulder area of the male, kneeling down over the male facing towards me. PC Ashley Tomlinson was next to Alan Smith. He was to Alan's right and he was also on his knees and he was leaning over the black male's right hip and buttock area. He was also facing my direction. I saw PC Alan Paton. He was standing up in close proximity to Alan Smith. He was standing over Alan Smith and Ashley Tomlinson, facing towards me. PC Craig Walker was standing to Alan Smith's immediate right facing me. I saw PC James McDonough kneeling down at the black male's feet. He had his arms tuck round the black males feet. This is a trained officer safety tactic to prevent somebody lashing out with their feet until such times as the police have full control of the person. James McDonough maybe looked like he was lying across the black male but I know he wasn't he was just controlling the movement of the black male's legs. That goes for Ashley Tomlinson and Alan Smith as well. It might look to a untrained person that they were just lying across the black male but that is a recognised training hold”. From acting Sergeant Maxwell’s explanation there is no assaultive behaviour occurring, upon his arrival.

18.2.6 Acting Sergeant Maxwell continued: “From what I seen, I thought the level of resistance given by the black male was reducing and quite quickly maybe as short as

---

[188] PIRC-00262
[189] PIRC-00266

twenty seconds he appeared to be fully compliant, but when I first saw him there was definite movement, struggling with his full body moving although the officers as I seen it had full control. As the black male became compliant my officers visibly started to back off and reduce the pressure applied. This was a natural phase, it was not as if I had to give verbal direction. The black male was not vocal at any time as I was aware. Most people who do resist are abusive and give plenty of verbal." And "When I saw PC Alan Smith, knowing that he was a officer safety and SPELS trainer, force trainer, I was confident in his abilities to control that situation in respect to restraint techniques and the after care of the male."

18.2.7 A general principle of restraint risk warning signs is when a violent person suddenly changes, and becomes compliant and quiet. Based upon the previous behaviour, the volume of force used against Mr Bayoh, and now his sudden compliance and calmness, he should be checked for vital signs and to establish if there is a medical need. Officers should reduce their response in line with the profiled behaviour. Those vital signs should be regularly checked throughout a restraint.

18.2.8 PC Alan Smith, who was a patrol officer, and part time OST trainer, recorded[190] that:

18.2.8.1 "I ran up the road and that's when I saw a number of officers and a male lying on the ground. As I got closer I saw that it was PC Walker, PC Paton and PC Tomlinson who were struggling with the male on the ground."

18.2.8.2 "He was lying on his left hand side facing towards Hendry Road. PCs Walker, Paton and PC Tomlinson were all were in kneeling type position to the back of the male. I would describe the struggle as the male struggling, moving his arms about, pulling his arms away from the officers, pulling himself up. I was aware that PC Tomlinson was struggling to control the legs but I wasn't aware what he was doing"

[190] PIRC-00278

18.2.8.3 “PC Paton was closest to the man's head, he was trying to control his arms leaning across the top of the man's shoulders and trying to get control of his arms. I do not know how much pressure he was using but he was over the shoulder of the male and the point of contact was at the top of the torso, male's right shoulder. He was not lying on the man's head or neck area. PC Walker was in the middle of the three officers at the back of the male, he was leaning across the male but further down his torso trying to get control of his arms. He was leaning over him face down. I do not know what level of pressure he was putting on the male, he was going from a kneeling position to lying flat. PC Tomlinson was further down the male's body at the top of the thighs/hips, trying to control the male's legs. I know PC Tomlinson was having to move about a lot at the bottom of the body but I do not know what exactly he was doing. I was more forward on the top of the male's body at his hands because of the knife threat, I had no idea what had happened to the alleged knife and I was coming round to the front of him. I cannot remember at what stage but a set of handcuffs were drawn by someone. It was not me but I do not know which officer. They were eventually applied to the male, he was handcuffed to the front.” And “At that time the profiled offender behaviour was active resistance as he was struggling with the officers with the additional impact factors: he may be in possession of a knife, he appeared so physically strong that three other officers were having difficulty controlling him, and incapacitant sprays were ineffective, and he had already shown a clear intent to assault police officers. If he did manage to break free it was likely the profiled offender behaviour would become assaultive or seriously aggravated resistance meaning that his actions could cause serious injury or death.”

18.2.8.4 “I moved to the front of the male's body (he was still on his side facing me) and I knelt down on the ground at chest level to the male. I could clearly see his hands, there was no knife in his hands or lying on the ground near the male. Between myself, PC Walker, PC Paton we managed to apply the handcuffs however as previously stated I do not know who's handcuffs were applied or who actually got them applied. I did not use my handcuffs at that stage, or my baton. The handcuffs were applied palm to palm to the front. The male continued to

struggle after the handcuffs were applied. We had control of his upper body although he was still resisting. I turned my attention to the male's legs as PC Paton had said he needs leg restraints"

18.2.8.5 "I moved down to the male's lower body (legs), that's when I became aware PC McDonagh was there, he had his leg restraints in his hands, I think he was standing up at that point. PC Tomlinson was attempting to control the legs, he was lying across the male's legs, the male's legs were lying in the prone position flat to the ground, knees to the ground by this time. I wasn't aware of any other officer being present at that point. I then attempted to get the male's legs straightened out to apply the fast straps, in the confusion I took a hold of PC Tomlinson's boot and started to pull his leg to straighten it out, I immediately realised it was not the male and let his boot go. I then took a hold of the subject's ankles and pulled his legs toward me to straighten the legs and get them together, all the while the subject resisted this, and tried to curl his legs up and move them to prevent me straightening them. I succeeded in keeping both his ankles together and turning his feet sideways, so they were facing down towards Hendry Road, preventing him from bending his legs at the knees and getting more control. Myself and PC McDonagh then succeeded in applying fast straps round the ankles, subject was still attempting to move is legs about, causing my hands to be trapped underneath his feet causing cuts to my fingers on my right hand"

18.2.8.6 "Myself and PC McDonagh did manage to get a second fast strap applied to just above the subject's knees. I assume the second set were also PC McDonagh's, they come in pairs. The fast straps were applied to the knees and ankles as they should be applied. At that point we effectively had the male subject under control, the risk of his becoming free had effectively gone. The handcuffs position to the front were not applied in the best possible way to eliminate risks to the officers as there was still some possibility of movement. In an ideal situation they would have been applied to the rear but due to the behaviour of the male subject this was impossible."

18.2.8.7 "Once the restraints were applied I stood up and checked the injuries to my hand, and was satisfied that they were superficial. I had a look at the male from

where I was standing, he was tilted over to his front, I'm not sure that he was completely prone. PC Walker said that we would have to get the male onto his side and I think PC Paton, PC Tomlinson and PC Walker moved him onto his side. I didn't hear the male say anything throughout this but he was moaning. I would say that from arriving in Hayfield Road, speaking to PC Short to the point that the male was effectively under control in handcuffs and fast straps that a period of 3-4 minutes had elapsed."

18.2.8.8 "I went down to check the male as I was aware he had been sprayed with CS/PAVA that had not worked, he was in leg restraints and due to these factors it is normal to carry out close observations of anyone this has happened to. I was also considering that as the male had not responded to CS/PAVA it is an indication that, along with the very aggressive behaviour that I had witnessed, it is an indicator of possible "excited delirium". This is this is taught as part of the OST training syllabus, this is usually associated with possible drug use/mental health problems and can lead to deterioration in medical condition and sudden death of a subject. Although I was considering this there was nothing that was giving me any immediate concerns about the male's condition."

18.2.8.9 "I was running through an aftercare procedure that was second nature to me. When I went down to the male I saw that his eyes were closed. I've initially tried to get a response to verbal stimulus, saying "Are you all right, can you hear me?" I think PC Paton also tried to speak to him. That produced no response. I then tried physical stimulus, putting my knuckles in the bone in the top of his chest to see if I got a response but I didn't get a response. At that point the male appeared to be unconscious. I checked his breathing by putting my face towards his mouth and heard and felt breath and could see his chest move consistent with normal breathing. At that point I said "he is breathing" and PC Paton has concurred."

18.2.8.10 "I immediately passed a radio message stating that the male is controlled highlighting the fact that the male appeared to be unconscious but breathing, and an ambulance was requested. At that point PC Tomlinson said to me "I've hit him on the head with my baton". He appeared worried. I cannot recall if I asked PC Tomlinson anything about that. I had a quick check of the male's

head and there appeared to be no obvious head injuries to me. Because of the potential for a head injury I did not move the male to carry out any further secondary survey." (This would correspond with the incident log at 07:25:17).

18.2.8.11 "I kept the male in the position he was in, which was almost the recovery position which is the correct position for an unconscious person to be placed in."

18.2.8.12 "I did not pass any update re the possible head injury via radio. I was aware PS Maxwell was standing there. I was aware that CID officers (DS Davidson and DC Connell) were in attendance. DS Davidson I recall was crouched down beside me, I do not know what DC Connell was doing. I was fully concentrated on the male at this point. I continued to observe him for about 3 minutes, at which point I became concerned that he wasn't breathing normally and his chest was not moving. I remember asking someone (I do not recall who) to take control of the male's head so I could go down and listen for breathing again. I went down to listen for breathing again and there was nothing obvious. Due to my concern I moved the male onto his back so I could check more thoroughly. I put my ear over his mouth, looking down the line of his chest, and within a few seconds determined that I couldn't feel, hear or see breathing. I immediately said we need to start CPR and PC Walker immediately started carrying out chest compressions."

18.2.8.13 "The period of time that elapsed between my starting the aftercare of the male and realising that he was not breathing was again only about 3-4 minutes."

18.2.8.14 "On arrival at the hospital I heard someone asking for the handcuffs to be removed."

18.2.8.15 "A lot of medical staff arrived and I stepped back to allow them to deal with the situation. I recall someone, a female, I assume she was a doctor, asked for the leg restraints to be removed."

18.2.8.16 "The handcuffs were removed as soon as the male was in the A&E Dept, the leg restraints a couple of minutes after that."

18.2.9 Acting Sergeant Maxwell stated[191] that:

18.2.9.1 "When I first arrived and on approaching the black male when he was on the ground I could clearly see he was handcuffed to the front. To my recollection leg restraints were already applied to the lower part of the black male's legs close to the ankles."

18.2.9.2 "PC Alan Smith remained down at the male as if he was keeping the male balanced on his left side. At this point Alan said to me as I walked to him that the male wasn't breathing he was unresponsive and clearly wasn't right. I watched as Alan carried out some checks. I saw him place his head or his ear to the male's nose and mouth area. He then checked the male's wrist, I don't know which one because he was still cuffed at this point. Alan then said that we needed to start CPR."

18.2.9.3 "From my awareness the time period between when the male became unresponsive to when Alan Smith declared CPR required was quite short."

18.2.9.4 "Whilst all this was going on, I basically was there as a supervisor."

18.2.9.5 "It was at this time that Ashley Tomlinson approached me. He looked in shock and he appeared to me as if he had done something wrong. He said to me something along the lines of "I may have struck this male on the head with my baton". From that I assumed that he meant only once. I never questioned him, I went straight onto the radio for the ambulance to be made aware and also for it to be recorded for transparency. I asked for an ETA for the ambulance. I worried for the male, I suspected his condition was as a result of being hit on the head with a police baton."

18.2.9.6 "I liaised with Inspector Kay who turned up after the ambulance had left. He arranged for staff to manage road closures and locus protection."

18.2.10 PC Paton recorded [192]:

---

[191] PIRC-00266
[192] PIRC-00262

18.2.10.1 “The boy was face up. He was always lying on his back face up. Craig was lying on his left hand side facing the boy's feet. Craig was lying across the chest of the boy”

18.2.10.2 “Ashley, Alan and Craig are big guys and they were struggling to control him. I remember hearing the guys talking about trying to get control enough to try and get handcuffs onto him.”

18.2.10.3 “I remember that Craig was still at the top end (chest) of the guy. I saw Craig get lifted by the guy. He was lifting Craig with his body weight. Craig is about 25 stones. I cannot emphasise the strength of this guy. Alan is an ex-marine. Ashley is a big guy as well. I'm thinking to myself if he gets back onto his feet then we've got real problems as well”

18.2.10.4 “I picked up the baton and put it across the boy's bicep. I had the baton across the boy's bicep. I was holding both ends of the baton and I was in a push up position with my whole body weight with the pressure on the baton over the boy's bicep but he was still struggling. I know that this is not a trained method of restraint but in the circumstances I was trying to bring him under control to assist with keeping in control and for handcuffs to be put on him”

18.2.10.5 “It was whilst I was still holding his bicep with the baton I noticed there was no resistance with regard him trying to lift up his arm. I am only really conscious of his arm. I could not really see the rest of the torso because of Craig's back. The guy did not speak or scream throughout the incident”

18.2.10.6 “Alan said at this point. He must have stood up at the head end, and said "Is he still breathing?" He was standing at the guy's left hand side of the head end. He was just in front of me. Alan then said "Aye, he is". I looked at the guy and in my opinion he was still breathing. I said "Aye, he's still breathing". I could see movement in his skin. I just thought that he was still conscious, I did not get down and check for breaths. Craig was still lying on top of the guy at this point. I was still on the ground with the guy”

18.2.10.7 “Alan is an Officer Safety Trainer and qualified in First Aid. He did my last refresher course as well. He is very methodical as well. I remember thinking if that's good enough for Alan then that's good enough for me”

18.2.10.8 “Around about the same time I remember hearing Ashley say "I hit the boy off the back of the head with my baton". I believe he said this for the benefit of A/Sgt Scott Maxwell who was present and was passing back radio transmissions”

18.2.10.9 “There was a small amount of blood above one of his ears, I cannot remember which one, it was from a cut or a graze”

18.2.11 PC Tomlinson [193]recorded:

18.2.11.1 “The man was face down, Craig was on his back trying to control him and I was on his upper thighs straddled over him trying to control his legs and facing his head. He started to bench press both of us and was incredibly strong. I tried to pull his right arm to stop him doing this and he started to pull me in. He was overpowering us and we were struggling to keep him on the floor. I would say Craig is about 20 stones, and he was still too powerful for us. He kept pulling me in and I pushed the emergency button for assistance.” (This is shown as activated at 07:21:19; arrival time was 07:20:23 – approximately 56 seconds between arrival/initial contact and ground restraint).

18.2.11.2 “My thoughts now were to try and get one of the handcuffs on him to control his arm, but he again flicked his legs, causing me to lose balance and drop my handcuffs. I managed to get back onto the back of his legs and at this point other officers started to arrive”

18.2.11.3 “I remember Alan Smith trying to put fast strap on the man, but he grabbed my leg by mistake and I asked him what he was doing. The man was still face down and still struggling”

18.2.11.4 “Craig shouted for someone to check for a knife. I checked his right side from his waist to ankle and by that time he had been rolled onto his side and was handcuffed to the front palm to palm”

18.2.11.5 “The man had calmed down and wasn't moving or struggling. Alan Smith bent down and put his ear to the man's mouth and confirmed he was breathing.

---

[193] PIRC-00263

He wasn't responding so Alan Smith or someone asked for an ambulance. Shortly after that Alan Paton said that the wasn't breathing. Alan Smith checked and confirmed this so we rolled him onto his back to carry out CPR"

18.2.11.6 "A stretcher appeared and I helped the man onto it face up helped by Alan Smith, Craig Walker and Alan Paton. We put him onto a stretcher on his back still handcuffed to the front and one fast strap to his lower knee"

18.2.12 PC Walker[194] recorded:

18.2.12.1 "So I just brought my left arm across my body and shoulder charged him with my left shoulder, with a fair bit of force. He (deceased) fell back towards the pavement. We both fell together into the pavement. As this happened I dropped the baton onto the ground somewhere. When I got onto the pavement I was on my knees, while he was on his back. I made attempt to get over of the top of his shoulders and hands to get him under control. As I did this he raised his shoulders and tried to punch me with his right hand. He tried this two or three times, I'm unsure whether these connected properly but I was still in a bit of pain in my eyes. He may have connected with my stab vest which affords you a lot of protection and I may not have been aware of punches connecting. As I leant over I then struck him a couple of times with a clenched fist in my right hand somewhere around his left cheekbone area. He continued to struggle and lashed out with his arms. He also tried to punch me again. I still couldn't manage to get proper control of him at that time."

18.2.12.2 "Eventually I got him (deceased) to the position where I had hold of his right wrist, which forced his arm across his body. I put pressure from my chest into his right shoulder, pushing him onto his left side. My body was in a crouched position over him with my knees on the pavement against his back so he couldn't turn back towards me to lash out. At this point PC Tomlinson came in from the right hand side and PC Paton came into my view from my left hand side near his

[194] PIRC-00264

(deceased) head. PC Paton had a baton in his hand and he knelt down and passed the baton under his left armpit and over the top of his forearm and held it down with both his hands, restricting him from any movement of his left arm."

18.2.12.3 "The struggle carried on the ground. I was unsure what PC Tomlinson was doing at this stage but I saw PC Smith when he approached directly across from me near the man's head. He had his CS Spray canister out in his left hand and had it pointed towards the man's (deceased) face, probably about 2 feet away. PC Smith said to him "If you don't stop resisting you will be sprayed". Given what had happened earlier I said to PC Smith "That'll no work on him, you'll just contaminate us" and pushed his hand away."

18.2.12.4 "I then reached onto my vest for my handcuffs and managed to get a cuff on his right wrist. However, just as I got it on he pulled away his hand and managed to get his hand free with the cuff still attached. He swung his arm up in the air but I managed to get a hold of the cuff again and pulled it down towards his left arm which was still pinned to the ground. I quite quickly got the other cuff onto his left hand which meant he was cuffed to the front. I really wanted to cuff him to the rear but that was the best that could be done at the time. At this time PC Paton still had the baton in place on his left arm. PC Tomlinson was to my right, although I wasn't aware of what he was doing. However once the cuffs were on and we had control of him I looked to the right and saw that leg restraints had been put on his legs."

18.2.12.5 "At this point I raised myself from the man (deceased) with my body up straight with my knees still on the ground. I think PC Smith took control of the handcuffs. PC Tomlinson was near to the man's (deceased) waist but I don't know if he actually had a hold of him. The man seemed to stop resisting us at that point, although PC Smith had control of the handcuffs, PC Paton still had the baton lodged through his arm and PC Tomlinson was restraining him to some degree. I say that because he was there, as I said I don't recall exactly what he was doing."

18.2.12.6 "me and PC Paton rolled him over from his left side onto his back. The baton was pulled out from his arm to facilitate this. He was fairly compliant at this time. He had never said a word at this time or before this."

18.2.12.7 “While I had the man in the form of ground, pinned on the pavement, when pressure was being applied to his left shoulder, I would say I held him in that position for a maximum of 30 seconds, until he broke free, after the handcuffs had been placed on him. There was no similar restraint holds on the man (deceased) after that part.”

18.2.12.8 “Just after I had spoken to DS Davidson I looked down at the man (deceased) and I thought he seemed unresponsive. His eyes were closed and I noticed he had phlegm coming from his nose. At this point he was lying on his back, he was handcuffed to the front, palm to palm and the leg restraints were still on. I thought to myself "Is he alright" and just at that PC Paton said to PC Smith "Gonna check him". PC Smith is an OST Instructor and First Aid Trainer, that's why he would have asked him. PC Smith knelt down beside the man (deceased) at his left hand side. He leaned down with his ear into his face, looking down onto his chest. PC Smith said "He's still breathing". PC Paton then, still kneeling beside the man's face, slapped him a couple of times on the face to see if there was any reaction. He (deceased) didn't move.”

18.2.12.9 “Smith then got on his radio and requested an ambulance for an unconscious/unresponsive male.”

18.2.12.10 “I started chest compressions.”

18.2.12.11 “PC Smith went back on the radio and updated the control room that the male was in cardiac arrest. I have no idea of the time at this point.”

18.2.12.12 “I weight my spray on a daily basis in the muster room where a new set of scales is kept. I weighed it on the morning of the incident and it was still 89 grams.”

18.2.13 PC Kayleigh Good was a probationer constable in company, in company with PC Alan Smith, and recorded the following[195] comments:

[195] PIRC-00274

18.2.13.1 “Sergeant Maxwell also made a request to the control room to ensure they were arranging an ARV, armed response vehicle and also a dog unit to attend the call. I think this was because there was a knife involved, and I think this is part of the protocol.”

18.2.13.2 “I was also thinking at that point of the Lee Rigby incident in London, mainly due to the fact of the coloured male and the potential terrorist connotations. In addition, I recall that there were many emotions going through my mind and I reminded myself of the briefing of when I first started at the turn of the year, where intelligence had been received by the police that there would be a potential attack on female police officer. I was actually shaking physically, it was uncontrollable. You don't really get training to deal with this sort of incident. It was fair to say that I was panicking at that point and was fearful for my own safety.”

18.2.13.3 “About 30 metres before we came to a stop I saw PC Nicole Short staggering in the right hand side pavement (North Pavement). She was holding her side, it was her right side, and I immediately thought that she had been stabbed.”

18.2.13.4 “I made my way around the front bonnet of our vehicle and ran to Nicole.”

18.2.13.5 “I could clearly see a black male lying on the pavement, face down. His chest was on the ground but his head was up off the ground and turned to the right towards Gallagher’s Pub. His feet were closest to me and his head was furthest away, facing south. At that point his arms and legs were still flying (kicking out, arms flaying) and he was trying to force himself up using his arms like a 'press up' type movement. At that time I saw several officers trying to restrain him, by pushing him to the ground. Alan Paton was at the male's head and I think he was trying to restrain the male with a baton. There is a technique where you place there baton through between a person's arms and his body, which takes the persons arm behind their back, with the baton extended. I don't remember what arm PC Paton was using for this technique but I do remember that the male, who I now know as Sheku Bayoh, but I refer to his as Shek, was so muscular that this technique was not working properly, and he, Shek, was preventing its correct application by

forcing his arm against it. I saw Craig Walker lying across the top of Sheku's back , towards the upper half, in an effort to stop him forcing himself to his feet. This was effectively to assist in pushing him to the ground. Craig only had the top half of his own body over Shek. I could see Alan Smith was at Shek's feet and he was trying to stop Shek kicking out. I don't recall if Alan was using his knees or his hand / arms to achieve this. James McDonough was kneeling next to Shek's left side and was getting his leg restraints out of their holder on his utility belt."

18.2.13.6 "Ashley Tomlinson was kneeling down next to Shek. I actually think he had one knee on Shek's leg, again attempting to pin it down. Shek was still violently struggling at this time. There was lots of shouting but to be honest it was a bit of a blur and I don't know who was shouting."

18.2.13.7 "So when James got his leg fast straps out he attempted to apply them to Shek's legs, just below the knee cap, but due to Shek struggling, violently, James was struggling to get the straps under his legs. Ashley and James were trying to feed the straps under his legs, but they were not able to do this. As I have smaller hands and arms I got down on my knees and pulled the straps through under Shek's legs and then Alan Smith fastened them at the top side of his legs, effectively at the back of Shek's legs, who was still chest down."

18.2.13.8 "As soon as Alan Smith got the straps applied, I think it was Alan Paton who said "Right, roll him onto his side," which is what every officer did. Shek was rolled up onto his left hand side. I don't think that he was handcuffed at this time, in fact I don't remember seeing his hands as I was at the side of his legs."

18.2.13.9 "When we rolled him onto his side I noticed that Shek had stopped struggling, and I could see his face then. I noticed that his eyes were shut at that time, but I could see no marks or blood on him, or his face."

18.2.13.10 "At that point I saw Alan Paton pat him on the cheek with his hand. I thought that Shek was faking it, as in he was faking that he was unconscious, as it is not unusual for people to do that when they are being arrested. In addition, it would be normal to check someone who you had just restrained. I specifically recall Alan Paton stating that he, Shek, was breathing."

18.2.14 PC Daniel Gibson [196]recorded that:

18.2.14.1 "PC Ashleigh Tomlinson was at the legs of the male, I'm not sure if PC Tomlinson was standing or on the ground. The male's legs were to the roadway, his head towards the houses. His whole body was on the pavement. I cannot recall if PC Tomlinson had a hold of the male at that point. PC Walker was struggling with the male, he was at the rear of the male who was on his left side, leaning over him and trying to grab the male's arms, the male was struggling, he was kicking his legs about, swaying back and forward with his arms and shoulders, I do not know if the male was handcuffed at that point. I do not know if PC Walker managed to get a hold of his arms or not. I do not remember anything being shouted by the male on the ground or by the officers at that point, it was just a struggle. PC Walker was having difficulty controlling the male at that point, so I decided to intervene and I went down onto the ground at the feet of the male."

18.2.14.2 "I lay across the male's legs."

18.2.14.3 "I could not see what any other officer was doing."

18.2.14.4 "The next thing I heard was someone saying "Get off him". I think it was PC Alan Smith. I got off the male's legs and got to my feet, the male was not struggling or anything then. I got up and stood at the male's feet facing him, the male was on his front, the left hand side of his face was on the pavement facing down to Hendry Road."

18.2.14.5 "That's the first time I saw the male was handcuffed, he was handcuffed to the front. I know that as PC Alan Smith checked the man's breathing."

18.2.15 PC James McDonough[197] recorded:

18.2.15.1 "I observed a black male lying on the ground. He was wearing a white t-shirt and blue jeans. He was lying on his stomach face down. I saw that there were officers dealing with this male. The officers were Alan Smith, Craig Walker, Alan Paton and Ashley Tomlinson. Alan Smith was on his knees and he was

[196] PIRC-00258
[197] PIRC-00273

attempting to control the male's legs as he was struggling and it looked like the male was attempting to evade detention. Craig Walker as also on his knees and he was facing towards me. I can't recall exactly what Craig was doing but he was at the male's waist area. Alan Paton was also on his knees and was next to the male's head and he was attempting to control the male's left arm and the male was struggling violently as if attempting to escape. Ashley Tomlinson was also kneeling at the male's head but with his back to me. He was attempting to control the male's right arm."

18.2.15.2 "I immediately went to Alan Smith's assistance and I got hold of the male's left leg. I was on my knees at this time. I grabbed the male's ankle with both of my hands. Alan Smith had a hold of the male's other leg. The male still appeared to have a lot of strength left in his legs as I was struggling to control him. I looked at my colleagues and saw that Daniel Gibson was trying to control the male's upper body. He was holding the male's arm. The male was still struggling and even although Daniel and myself were assisting we were all having difficulty controlling the male."

18.2.15.3 "I had a glance around the male and I couldn't see any knife. My colleagues were still trying to secure the handcuffs on the male. I decided to stand up and have a look for the knife as Alan Smith and myself had secured the leg restraints. Throughout the whole incident the male was lying on the pavement."

18.2.15.4 "I can't recall if any of my colleagues were giving instructions to the male. I decided to stand back as I thought I would get in the way and hinder my colleagues. Although I've said I didn't want to hinder my colleagues I did kneel down at his feet and I still took hold of his legs however due to the leg restraints he was unable to kick out. He was able to move his legs slightly with the leg restraints and I could still feel the muscles in his legs tensing up. I then recall suddenly his legs not moving. I'm not sure who it was but somebody said at this point "he's motionless". I stood back as did the rest of my colleagues. The male was still only handcuffed on one wrist. I saw that the male wasn't moving."

> **18.2.15.5** "Alan Smith and Alan Paton then crouched down and went to the male's head area. Although the male wasn't moving one of the Alan's, I'm not sure which one said "he's still breathing"."

18.2.16 The basic principles concerning the use of force is that the continuum is fluid. If Mr Bayoh becomes compliant, then the use of force reduces. In addition to this there is constant monitoring for vital signs (DR ABC) and signs of any physical deterioration.

18.2.17 A significant principle for any restraint procedure is for the officers to act as a team. This enables an efficient manual handling process with co-ordinated movement. This requires an officer to take control and become the 'controller' or 'supervisor'. This role is not rank specific. It commonly sits with the person at the head area of the subject, who can also monitor vital signs and see down the body for alignment. If the procedure is co-ordinated then all officers should be aware of what is occurring. In this incident the officers were not aware of the team effort, and their actions could be counter-productive when acting in isolation. A co-ordinated approach also enables clear directions to be provided to the subject and the officers, so all persons are aware of what has occurred and what the process is to entail.

18.3 What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?

18.3.1 Acting Sergeant Maxwell states that "the level of resistance given by the black male was reducing and quite quickly maybe as short as twenty seconds he appeared to be fully compliant". If this was the case, a reasonable officer response would be to complete the initial mechanical restraints quickly, commencing vital signs checks, and obtaining a side position to have Mr Bayoh neither prone nor supine.

18.3.2 As the formal supervisor at scene, Acting Sergeant Maxwell did still have a responsibility for the safety of the restraint procedure, as did every member of the restraint

team. Mr Bayoh is officially a detainee, and all custody procedures apply. Acting Sergeant Maxwell would have been able to act as the restraint 'supervisor' which is a role for a person not involved in the physical restraint. They take a holistic safety overview for the safety of detainee and staff. No officer states that any person was providing the overall co-ordination of the restraint.

18.3.3 A reasonable officer response would be to implement a co-ordinated restraint process, with an officer announcing the tactics and safety measures.

18.4 What level of response was appropriate?

18.4.1 A co-ordinated and controlled restraint was an appropriate response. Restraint should never be viewed purely as a physical technique. Constant assessment of risk is required throughout any restraint process.

18.5 What tactical options were open to the officers involved in the restraint (i) initially, and (ii) as the restraint progressed?

18.5.1 The tactical options include obtaining a rapid control of the person, and this commonly involves initial prone position, as it is the most efficient for controlling a person.

18.5.2 Prone position should not have any weight placed into the torso of the person which may impact upon the diaphragm movement, lungs, or wind pipe. This means from stomach to throat should be without any pressure.

18.5.3 Rear handcuffing, and 'fastraps' to the ankles, has the person contained sufficiently to move them into a side position. Linking of handcuffs can be used if the arms are not able to be brought together sufficiently. I have on one occasion required three sets of handcuffs to link, in order to achieve initial handcuffing.

18.5.4 Pressure to the limbs should also be removed as soon as possible due to the theory this can create an increased risk for a person.

18.5.5 If pressure is required on a person, the primary areas should be muscle mass areas such as biceps and thighs, with a large surface area from the officer. Use of a baton to push down pressure will exert a high level of pressure into a small surface area and could cause additional risk.

18.5.6 Physical pressure must be reduced as soon as possible, and the medical risks of the detainee assessed.

18.5.7 As risk factors were present such as extreme strength, no impact of CS and PAVA, several strikes by a baton to the head and use of the baton to exert pressure through the arm - it is clear that Mr Bayoh would need medical attention prior to custody. The requirement for an ambulance should be known, and an ambulance requested, before he becomes unconscious.

18.5.8 The Care and Welfare of Persons in Police Custody SOP[198] applies to all persons from initial contact and arrest. The responsibility for the detainee's health and safety rests with the arresting and escorting officers until he is handed over to the Custody Sergeant. The officers at scene must safeguard a detainee's wellbeing. The SOP includes:

18.5.8.1 "Consideration must always be given to immediate medical needs or mental health assessments required"[199]

18.5.8.2 "Any apprehension should be made with the minimum amount of force necessary."[200]

18.5.8.3 "Any requirement for immediate or urgent medical provision takes priority over apprehension. These circumstances may include"[201] The SOP then lists

[198] PS11014; PS17915; PS17918
[199] Section 5.1.2, page 13
[200] Section 5.1.3, page 13
[201] Section 5.3.2, page 13

examples which includes head injury, unconscious, difficulties after exposure to CS/PAVA, drink or drugs intoxication, any other medical condition requiring urgent medical attention.

18.5.8.4 Section 5.3.5[202] covers where a person apprehended is moved directly to hospital the arresting officer must contact the custody Sergeant and the immediate supervisor.

18.5.8.5 Section 13.4[203] covers the 'rousability' test for detainees. If a detainee cannot be 'roused' as per the SOP, medical assistance must be called, and "if in doubt call an ambulance."

18.5.8.6 At section 13.19[204] the issue of violent/deranged person is recorded. Full public order PPE is the process for dealing with a violent/deranged person in a custody unit. As a PSU Sergeant I have conducted and/or supervised PPE cell extractions within custody units, using shields.

18.6 Please identify all factors relevant and material to your assessment of the option(s) available

18.6.1 The main principles to consider for a ground restraint is that this is high-risk for detainees and staff. The objective is to achieve control as soon as possible and as safely as possible.

18.6.2 A violent deranged person who then suddenly becomes passive indicates a significant warning sign. Officers know he has been struck to the head with a baton in addition to CS and PAVA. PC Walker noticed fluid coming from his nose.

18.7 What option(s) would a reasonable officer have chosen? Why?

---

[202] Page 14
[203] Page 50
[204] Page 56

18.7.1 The reasonable officer would have acted as part of a team to co-ordinate a quick and safe control procedure. It should be apparent during the process that Mr Bayoh requires a medical assessment at hospital prior to detaining in a cell. The ambulance should have been requested earlier than it was, as preservation of life takes priority.

18.8 On balance of probabilities, what difference might the choice of that tactical option(s) have made?

18.8.1 The removal of officer force as soon as possible may reduce the amount of exertion from the detainee. The recognition of a medical need earlier would have instigated withdrawal of officer force sooner and the calling of an ambulance earlier.

18.8.2 Acting as a co-ordinated team throughout the restraint, with a safety officer function being performed throughout, would ensure that no pressure was being placed upon the torso and head areas, and that the vital signs (DR ABC) were regularly being assessed. The aim would be to get Mr Bayoh off the ground whilst still conscious, or rapidly identify any decline in health and summon the ambulance crew at the earliest opportunity.

18.9 Please categorise and comment on the response by the officers. In particular, indicate to what extent, if any, their response differed to that of a reasonable officer or officers

18.9.1 As above, a controlled restraint was required, with a controller function and safety officer function being performed as soon as possible from the beginning. Regular checks of vital signs (DR ABC) were required and the recognition of when to call a ‘medical emergency’. There were sufficient officers there in order to have an individual perform this function and report to ACR. The first request for an ambulance crew to attend to Mr Bayoh was at 07:25:17 compared to one being requested for PC Short at 07:23:34, nearly 2 minutes earlier. They both required medical attention for a strike to the head plus Mr Bayoh had additional risks to take into consideration.

18.9.2 Concerning first aid. I was a civilian first aid trainer from 2012 until 2021 inclusive. A common misconception is that a first aid assessment is to establish if they are a breather or non-breather. This is incorrect. The Resuscitation Council Guidelines are issued every 5 years for guidance on the delivery of first aid training. We have the 2010-2015 and 2015-2020 guidelines relevant to this area of time. The 2010 guidelines states that "rescuers begin CPR if the victim is unconscious or unresponsive and not breathing normally."[205] The emphasis is concerning 'normal' breathing and 'not normal', not whether or not there is any breathing.

18.9.3 The 'chain of survival' was being taught as the core principle reference, with the first aspect requiring the early recognition that a person needs help. This can be prior to unconsciousness or unresponsiveness.

18.9.4 Resuscitation Council Guidelines which should be taught to all first aid trainees would include:

18.9.4.1 A person "who is trained and able should assess the collapsed victim rapidly to determine if the victim is unresponsive and not breathing normally and then immediately alert the emergency services".

18.9.4.2 "The victim who is unresponsive and not breathing normally is in cardiac arrest and requires CPR."

18.9.4.3 "Survival after an asphyxia-induced cardiac arrest is rare and survivors usually have severe neurological impairment. During CPR, early effective ventilation of the lungs with supplementary oxygen is essential."

18.9.4.4 "Agonal breathing (occasional gasps, slow, laboured or noisy breathing) is common in the early stages of cardiac arrest and is a sign of cardiac arrest and should not be confused as a sign of life." And "Agonal breaths are slow and deep breaths, frequently with a characteristic snoring sound."

---

[205] https://vdocuments.net/resuscitation-guidelines-2010.html

18.9.4.5 Normal breathing for an adult is to be established within 10 seconds maximum. If normal breathing is unknown/cannot be confirmed it should be considered as 'not normal'. Normal breathing is effortless and quiet, within the 10 seconds.

18.9.4.6 "Defibrillation within 3–5 min of collapse can produce survival rates as high as 50–70%."

18.9.5 A 'normal' breathing rate for an adult is between 12 and 20 breaths per minute. In 10 seconds this would equate to at least 2 breaths, and 3 maximum. Outside of this means the breathing is not normal, if the person is unconscious/non-responsive then a medical emergency should be declared and CPR commenced.

18.9.6 During the restraint PC Alan Smith stated he had completed the 3-day first aid at work course in 2014. I was teaching this course in 2014 and 2015. He recorded:

18.9.6.1 "Once the restraints were applied I stood up and checked the injuries to my hand, and was satisfied that they were superficial. I had a look at the male from where I was standing, he was tilted over to his front, I'm not sure that he was completely prone. PC Walker said that we would have to get the male onto his side and I think PC Paton, PC Tomlinson and PC Walker moved him onto his side. I didn't hear the male say anything throughout this but he was moaning."

18.9.6.2 "I was running through an aftercare procedure that was second nature to me. When I went down to the male I saw that his eyes were closed. I've initially tried to get a response to verbal stimulus, saying "Are you all right, can you hear me?" I think PC Paton also tried to speak to him. That produced no response. I then tried physical stimulus, putting my knuckles in the bone in the top of his chest to see if I got a response but I didn't get a response. At that point the male appeared to be unconscious. I checked his breathing by putting my face towards his mouth and heard and felt breath and could see his chest move consistent with normal breathing. At that point I said: "he is breathing" and PC Paton has concurred. I immediately passed a radio message stating that the male is controlled highlighting the fact that the male appeared to be unconscious but

breathing, and an ambulance was requested." At this point PC Smith identified that Mr Bayoh was not responsive and he had failed the 'rousing' test. In light of the other relevant risk factors i.e. CS/PAVA not working, being struck to the head, and extreme strength I believe the medical emergency should have been declared by this point, and if any doubt about breathing being 'normal' CPR commenced.

18.9.7 An unresponsive person who is breathing normally is advised to be placed into a lateral, side lying recovery position as opposed to supine. They still require urgent medical attention. For the purpose of a medical emergency – unresponsive, not breathing normally and requiring CPR, all restraints should be removed from the person. This is due to preservation of life being the priority. Additionally, a detainee should receive medical attention without restraints unless the risk assessment deems that safety outweighs their entitlement to medical attention without restraint. A Home Office[206] spokesperson said : "New guidance on the use of restraints on detainees under escort was issued in 2014, with a presumption against their use for medical visits." This is to comply with European custody standards. The British Medical Association (BMA) 2009 publication[207] concerning the medical role in restraint and control, looked at the issue of detainees/prisoners being brought to NHS premises, and stated: "Health professionals are often unsure as to whether they are entitled to ask for handcuffs to be removed during assessment and treatment and whether they can ask accompanying guards to leave the room. They should certainly do so if the method of restraint interferes with treatment or if the detained person is clearly too incapacitated either to threaten others or to abscond." The information suggests that Mr Bayoh was left in handcuffs and leg limb restraint until after being admitted to hospital, and throughout CPR being performed on him by the police officers. If CPR is being performed on a person it is because they are unresponsive and not breathing normally, if at all. They are not in any fit state to escape or cause harm and the principle should be the removal of the restraints. For the purpose of BTEC awards

206 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/543806/DSO_07-2016_Use_of_Restraints.pdf ; [2012] EWHC 1804 (Admin) FGP and SERCO PLC;

207 https://fflm.ac.uk/wp-content/uploads/2009/03/1236269117.pdf

for safe restraint practices, it is mandated that the candidates must remove all restraints if they declare a medical emergency.

18.9.8 A definition for first aid includes helping behaviours and initial care, provided for illness or injury. You do not have to be a 'qualified' first aider to provide initial first aid to a person who has taken ill. The objective is for an untrained medical professional/bystander to provide care and responses to preserve life, prevent the condition from worsening and to promote recovery, until medical professionals are available.

18.9.9 DC Samantha Davidson stated that she placed her fingers to Mr Bayoh's neck looking for a pulse at one point, prior to PC Walker commencing chest compressions. The requirement for pulse checking was removed from first aid training due to the inaccuracies it produces, and the 'not breathing normal' procedure had replaced it by the 2005 Resuscitation Council guidance.

18.9.10 In summary, I believe the reasonable officer should have identified sooner that Mr Bayoh was a medical emergency. For example when they requested an ambulance for PC Short at 07:23:34, one should also have been requested for Mr Bayoh as he too had sustained strikes to the head. Prior to this when PC Smith updated ACR at 07:21:38 that Mr Bayoh was secured on the ground, this was when an ambulance should also have been requested due to the multiple risk factors identified above for some form of delirium and/or mental ill health. Had the ambulance been requested at 07:21 instead of 07:25 this would have saved approximately 4 minutes.

18.9.11 Once Mr Bayoh became unresponsive and not breathing, CPR was commenced at 07:29. All restraints should have been removed. In my opinion, he should not have been transported to hospital still handcuffed and with limb restraints in place.

19. Question 6 Hypothesis 2: supine restraint

- **Please categorise Mr Bayoh's offender behaviour during the restraint**
- **What impact would Mr Bayoh's behaviour have had on a reasonable officer's assessment of risk?**
- **What level of response was appropriate?**
- **What tactical options were open to the officers involved in the restraint (i) initially, and (ii) as the restraint progressed?**
- **Please identify all factors relevant and material to your assessment of the option(s) available**
- **What option(s) would a reasonable officer have chosen?**
- **Why?**
- **On balance of probabilities, what difference might the choice of that tactical option(s) have made?**
- **Please categorise and comment on the response by the officers. In particular, indicate to what extent, if any, their response differed to that of a reasonable officer or officers**

19.1 There are conflicting accounts as to whether Mr Bayoh was in any part of a prone or supine restraint. However, my earlier answers similarly relate to supine. Both positions can pose risk to the diaphragm and respiratory system, and the restrained person should be turned into a side position as soon as possible, with onward transfer to seated and standing.

19.2 The same restraint controls apply for a person to be constantly monitored and for their vital signs (DR ABC) to be regularly assessed.

19.3 Similarities are often shared throughout the European secure custody estate concerning deaths in custody. "Individuals being in a combative agitation and delirium

can be involved in a violent confrontation with the police and during the restraint they become quiet, calm then unresponsive."[208]

19.4 Dr John Parkes' article[209] recorded:

> **19.4.1** "Current guidance within the NHS states that all restraint positions should be considered to present equal risk."
> **19.4.2** "Participants restrained face down with the body weight of the restraining persons pressed on their upper torso and/or in a flexed restraint position showed a significant reduction in lung function."

19.5 Although prone position restraint is shown to be detrimental to a larger demographic, supine restraint can also be detrimental to persons with certain risk factors such as excess weight to the stomach/torso area. This causes the weight to press downwards and reduce the efficiency of the respiratory function. Being held with the back against the ground also prevents the full expansion of the chest. Even without the restrained person having excess weight, if the restraint team place any pressure against the torso of the person being restrained, this can prevent the respiratory system from functioning effectively.

19.6 If Mr Bayoh was in a supine position (that is held on his back), and PC Walker was leaning over any part of Mr Bayoh's torso, from naval to throat, this will impact on his ability to breathe. If PC Walker was around 25 stone and placed part of his weight across the stomach this is still likely to impact upon the diaphragm as it is placing a weight across the torso and preventing full expansion movement of the respiratory function. A reasonable officer would not place their body across the stomach or chest of a person during a restraint. There were sufficient numbers of officers present in order to conduct a relocation technique of a violent and deranged person.

---

[208] Forensic science and medicine. D.L. Ross & T.C. Chan. 'Sudden Deaths in Custody' 2006
[209] Medicine, Science and Law. 'Sudden Death during Restraint: Do some Positions affect Lung Function' April 2008 pages 137-141 https://pubmed.ncbi.nlm.nih.gov/18533573/

20. Question 7. Restraint: general

We invite your comments on:

- **20.2 The length of the restraint**
- **20.3 The number of officers involved in the restraint at different stages of the restraint**
- **20.4 The force applied to Mr Bayoh as he lay on the ground, insofar as you are able**
- **20.5 PC Paton's use of a baton during the restraint**
- **20.6 By reference to the enhanced Snapchat footage and stills from same; the evidence (which is in dispute) that Constable Walker (who weighed 25 stones) lay across Mr Bayoh's back**
- **20.7 The evidence (from a number of witnesses) that the restraint bore resemblance to a "collapsed rugby scrum"**
- **20.8 Whether a reasonable officer would have monitored or arranged to have monitored, Mr Bayoh's breathing during the restraint**
- **20.9 The significance of environmental factors (weather, temperature, Mr Bayoh's state of dress)**

20.1 General restraint information

20.1.1 Restraint principles and practices are comparable throughout the UK, and across all secure sectors. BTEC awards, and other certified training courses are also available to achieve through certified competences and standards. Police use of force training is not externally accredited by an awarding body. As stated by Inspector James Young in his Inquiry statement[210], Police Scotland were delivering differing versions of officer safety training dependent upon where the training was delivered, and by whom.

20.1.2 The Equality and Human Rights Commission 'Human Rights Framework for Restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions'[211], although published in 2019 summarised many issues I have identified in my report, and which were commonly being taught throughout the UK.
This document states:

> **20.1.2.1** "An act of restraint must comply with the basic legal principles below when carried out by a person performing a public function or providing a public service, whether they are employed by the state or private contractors. This includes restraint by teachers, police, prison and immigration detention officers, NHS and social care professionals. The principles in this framework serve to protect and respect the safety and dignity of people being restrained, as well as those around them, including staff or members of the public."[212]
>
> **20.1.2.2** The framework "sets out key principles of articles 3, 8 and 14 of the European Convention on Human Rights (ECHR), incorporated into domestic law by the Human Rights Act 1998, which govern the use of restraint across all settings…"[213]
>
> **20.1.2.3** "Example: Handcuffing a prisoner to a hospital bed, or during a medical examination, is humiliating and diminishes their dignity. It may be unlawful if the

[210] SBPI-00153
[211] https://www.equalityhumanrights.com/en/publication-download/human-rights-framework-restraint
[212] Page 4
[213] Page 4

prisoner does not pose such a risk of harm to the public or escaping that the handcuffing is necessary."[214]

20.1.2.4 "the means of restraint and its duration must be necessary, and no more than necessary, to accomplish the aim. This requires consideration of whether there is a less intrusive measure that could reasonably achieve the aim."[215]

20.1.2.5 "This requires consideration of any reasons why an individual may be particularly vulnerable to harm, such as their age, experience of trauma, health conditions or disabilities"[216]

20.1.2.6 "Where restraint is used, protective steps must be taken to ensure legality and prevent harm"[217]

20.1.3 The United Nations 'Basic Principles on the Use of Force and Firearms by Law Enforcement Officials'[218] was published in 1990 and is referred to within the 2019 Equality and Human Rights Commission publication. This 1990 direction states: "law enforcement officials shall:" and includes the comments:

20.1.3.1 "Exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objective to be achieved."

20.1.3.2 "Minimize damage and injury, and respect and preserve human life."

20.1.3.3 "Ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment."

20.1.3.4 "Ensure that relatives or close friends of the injured or affected person are notified at the earliest possible moment."[219]

20.2 The length of the restraint

---

[214] Page 5
[215] Page 7
[216] Page 7
[217] Page 8
[218] https://www.ohchr.org/en/instruments-mechanisms/instruments/basic-principles-use-force-and-firearms-law-enforcement
[219] Paragraph 5

20.2.1 There is no definitive time as a minimum or maximum for restraint. Previous inquiries, as mentioned earlier, have suggested a maximum of 3 minutes for a prone restraint, however, there is no time constraint. It is commonly accepted that the longer a restraint proceeds, the greater the risk, and the more staff involved, the greater the risk. The key safety principles include the fact that staff should be constantly assessing the necessity to restrain and the wellbeing of the detainee.

20.2.2 The timeline concerning Mr Bayoh shows that officers arrived to confront him at 07:20:23 hours, and by 07:20:42, approximately 21 seconds later, PC Paton's emergency button had been activated.

20.2.2.1 By 07:21:13, it appears that a person/person(s) have gone to the ground. This appears to be the start of the ground restraint.

20.2.2.2 By 07:21:19, PC Tomlinson's emergency button has been activated. PC Tomlinson states this was when Mr Bayoh was on the ground in prone with him and PC Walker, and had bench pressed himself upwards moving the two officers upwards. This confirms that the ground restraint was confirmed to be in progress by 07:21:19.

20.2.2.3 By 07:21:38, PC Smith states that Mr Bayoh is secured on the ground and that PC Short had been punched to the back of the head. This implies that Mr Bayoh is secured within approximately 25 seconds of him being taken to the ground. Formal safety checks (DR ABC), and reduction of officer pressure should occur, and he should be turned to his side as soon as possible, to relieve any pressure from prone or supine. PC Tomlinson should be requesting an ambulance concerning the head strikes and updating ACR concerning the head strikes, but all officers present have sufficient information to believe Mr Bayoh requires medical attention. PC Smith has passed the information that PC Short was struck to the head, but does not pass any information concerning Mr Bayoh's medical concerns.

20.2.2.4 By 07:22:10, Mr Bayoh is recorded as being on the ground and six officers are seen with him. There is ample opportunity to request an ambulance.

Police restraint techniques are commonly taught for single officer, two officers together, and three person techniques. A six-person technique is not a taught 'approved' technique, however may still be justified as being required. I have been

involved with five officer restraints with me as the supervising officer. But, six officers indicates that they require co-ordination and there should be adequate opportunity for a person to perform the role of the controller and/or safety officer. Six people involved in a restraint can be counter-productive if not coordinated, as they attempt different anatomical movements of the detainee. People fail to recognise what each person is doing and what each person is responsible for. Six people around a restrained person can also prevent safety observations as line of sight becomes obstructed.

20.2.2.5 By 07:22:24, PC Walker updates that Mr Bayoh is in cuffs and is still struggling.

20.2.2.6 By 07:23:13, (2 minutes after the ground restraint commenced) DS Samantha Davidson updates control that Mr Bayoh was still on the ground and that there was "no risk at the moment". In her Inquiry statement[220], she stated Mr Bayoh was "face down" on her arrival. Upon her arrival she reported that PC Walker was able to have a brief conversation with her during the restraint, concerning PC Short and the vehicle keys. She stated that Mr Bayoh was in a prone position and leg restraints were currently being applied. This indicates officers were able to pass information to ACR concerning Mr Bayoh. DS Davidson stated that Mr Bayoh was physically moving at this time.

20.2.2.7 By 07:23:34, Acting Sgt Maxwell requested an ambulance for PC Short due to her having been struck to the head. At this point no ambulance has been requested for Mr Bayoh, and it should have been. PC Tomlinson knew that he had delivered approximately 4 strikes to Mr Bayoh's head. Acting Sergeant Maxwell stated that when he initially attended, and prior to being with PC Short, he was told that Mr Bayoh had CS and PAVA sprayed at him with no effect. He also stated Mr Bayoh became fully compliant and stopped struggling within approximately 20 seconds of his arrival (Log showed he arrived at 07:21:48). Acting Sergeant Maxwell stated he did not know about the head strikes until after CPR commenced, but at the time of asking for the ambulance for PC Short he did know that Mr Bayoh had shown extreme strength and

[220] SBPI-00038

had not responded to CS or PAVA. Acting Sergeant Maxwell should have also requested an ambulance for Mr Bayoh for safe custody of the detainee.

20.2.2.8 By 07:24:11, Dog unit confirms they are en route to scene, from Edinburgh.

20.2.2.9 By 07:24:28, Acting Sergeant Maxwell repeats his request for an ambulance for PC Short ASAP due to her having been stomped on and struck.

20.2.2.10 By 07:25:17, PC Smith requests an ambulance for Mr Bayoh stating "unconscious, breathing, not responsive". This is approximately 4 minutes after Mr Bayoh was taken to the ground. He should have been identified immediately as requiring an ambulance due to the volume of risk factors associated with him. No reasonable Custody Sergeant would accept him at police custody without him first attending hospital.

20.2.2.11 By 07:26:52, Acting Sergeant Maxwell reports to control that Mr Bayoh "there may be a suggestion that he has been battened to the head area".

20.2.2.12 By 07:29:30, there is an update to control that Mr Bayoh is not breathing and CPR is commencing.

20.2.2.13 By 07:31:22, There is a request to control regarding the whereabouts of the ambulance for Mr Bayoh. ACR replies "They've been given a hurry up".

20.2.2.14 By 07:34:08, an ambulance arrives. This is approximately 13 minutes since the restraint began, and 12 minutes since Control was informed that Mr Bayoh was secured; approximately 9 minutes since an ambulance was requested for Mr Bayoh. The second ambulance was then requested for checking all officers at scene.

20.2.2.15 By 07:37:56, Mr Bayoh reported as being on the ambulance stretcher.

20.2.3 The length of the restraint has to be managed to keep it as safe as possible for all parties, and for the shortest possible time. This is where management of the restraint is a critical factor. The safer the position, the longer the restraint may be safe to continue and vice versa. As soon as a detainee is secured they should be moved to a side position, seated position and then standing position. If they are incapable of sitting or standing then an ambulance must be called.

20.2.4 A 4 minute restraint for a fit and healthy person, with no exertion, no underlying medical condition and no/little compression to their respiratory system is unlikely to be seriously detrimental, even if in prone. If Mr Bayoh was on the ground for all of the 4 minutes, with officer body weight across or up against his torso in conjunction with the warning signs described by officers of extreme strength, not affected by CS/PAVA, and struck multiple times to the head, then suddenly stopped resisting during the restraint, at this point of sudden change, this is a significant opportunity to identify the medical emergency and stop the restraint. (Restraint includes physical holding, handcuffs and limb restraints). Whether he was prone or supine would have little variation if weight was preventing the full function of his respiratory system. To continue a physical restraint once a person is secure is unsafe, and the prone/supine restraint is too long. Mr Bayoh was reported as being "secured" at 07:21:38. This is when vital signs (DR ABC) should regularly commence and the objective should be a co-ordinated movement into a side position, seated position and then standing. If he was not capable of sitting or standing then this is an additional risk factor, and an ambulance must be called.

20.2.5 At 07:21:38 when it was first announced that Mr Bayoh was 'secured', it is still possible to secure a person who is struggling. 'Secured' means that the police have a level of control of the person to prevent escape or assault. A person could be both handcuffed and limb restraints applied but still be struggling, and yet be 'secured'. A person does not have to be passive and compliant to be 'secured'.

20.2.6 When PC Walker updates ACR at 07:22:24 that Mr Bayoh is in "cuffs still struggling" he can still be classed as 'secure' if officers believe they have a level of control to prevent him escaping or assaulting people.

20.2.7 When a detainee is 'secured' this indicates that staff are available to update ACR with any relevant information and commence the health observations – DR ABC. On this basis DR ABC checks should be occurring from 07:21:38.

20.3 The number of officers involved in the restraint at different stages of the restraint

20.3.1 Officers train based upon 1, 2 and 3 officer restraints as standard practice. Some detainees do require additional staff. As also described by Christopher Fenton[221] it may be necessary to have 5 people conducting the restraint – one person with each limb and a head officer. Additional staff would be able to perform supervision and additional safety roles. If only 1 person was laying over Mr Bayoh's respiratory system, then this is one person too many, and an unsafe practice. If Mr Bayoh is in prone or supine and body weight is in any way pushing into his torso, this can impact upon his respiratory function.

20.3.2 Witness Christopher Fenton is a community psychiatric nurse. He provided a statement to the Inquiry. He described the restraint "like a pile of bodies on top of somebody". He further stated it looked like a "rugby scrum". He was of the opinion that Mr Bayoh was in a prone position. As a psychiatric nurse his restraint training is also aligned to the UK 'safer custody' and European standards, as part of the National Preventive Mechanism. The same principles of practice apply within a mental health setting as they do for police officers. Mr Fenton also comments that you would want to remove a person from prone as soon as possible. He also stated that he had experience dealing with persons who were suffering from an acute behaviour disturbance. He also referred to the practice of the head person monitoring the restrained person breathing.

20.3.3 Witness Abdeloouhab Guessoum provided a statement[222] stating that as they drove by the incident they saw that Mr Bayoh was in a prone position and "There was one police officer had a knee on his shoulder holding him down and another holding his legs and another officer in the middle but I don't know what he was doing."

20.4 The force applied to Mr Bayoh as he lay on the ground, insofar as you are able

[221] SBPI-00011
[222] COPFS-00042

20.4.1 The main factor concerning the application of force against Mr Bayoh, in my opinion, was not necessarily each individual technique but collectively based upon the full circumstances and medical implications, and the lack of apparent control and safety measures.

20.4.2 Over a period of just over 4 minutes for the duration of the restraint, officers used force to compress different parts of his body:

20.4.2.1 A baton over the bicep;

20.4.2.2 Officers over his legs; and

20.4.2.3 Allegations of an officer over his torso, or against his torso.

Prior to this occurring there had been a period of time where it was evidenced that Mr Bayoh was exhibiting bizarre and violent behaviours comparable to what is taught to officers as being possible ABD/excited delirium.

20.4.3 Mr Bayoh had been sprayed by three officers who used CS and PAVA without effect. He was reported to have an unexpected super strength and was struck to the head with a baton at least 4 times, face punched and multiple strikes to the body.

20.4.4 Acting Sergeant Maxwell stated Mr Bayoh was compliant after approximately 20 seconds.

20.4.5 Mr Bayoh was found to be unresponsive, unconscious and making noises which were described as breathing and moaning.

20.4.6 PC Walker stated that mucus was coming from Mr Bayoh's nose. First aid training teaches for first aiders to look for any fluid coming from the ears or nose as a medical emergency.

20.4.7 PC Paton stated that PC Walker was laying "on top of" Mr Bayoh. A member of the public described what looked like a 'collapsed rugby scrum' with officers laying on top

of Mr Bayoh. Without digital footage of the full restraint it is not possible to confirm exactly what occurred, by whom, and when.

20.4.8 The digital footage which has been disclosed to me is referred to as 'snapchat footage'. This shows approximately 5 seconds of the incident which is recorded by civilian witness Ashley Wyse from a distance and is too poor quality to enable me to analyse officer actions.

20.4.9 If an officer was laying over Mr Bayoh's torso, regardless of whether he was in prone or supine, this would impact upon Mr Bayoh's respiratory function. The heavier the officer, the more it would impact. As explained earlier in my report, if the diaphragm is unable to move correctly, this prevents oxygen inhalation by the lungs.

20.4.10 If Mr Bayoh was on his side but officer(s) were pressed tight to his torso this will also negatively impact upon the respiratory system. When a person is restrained there should be no external pressure being asserted into their torso.

20.4.11 Once Mr Bayoh was handcuffed, and leg restraints had been applied, there would be no requirement to apply any force to him at this point. The objective of preventing him escaping or attacking any person has been achieved. The incident log shows that handcuffs were applied by 07:22:24 and Mr Bayoh was declared unconscious at 07:25:17.

20.4.12 By 07:22:10 Mr Bayoh is recorded as being on the ground and six officers are seen with him. DS Davidson updated ACR at 07:23:13 concerning "gonna need more control with leg restraints".

20.4.13 I am unable to establish exactly when leg restraints were applied. Following application of the handcuffs the next objective should be application of the leg restraints and get the detainee onto their side. There was nearly 3 minutes between notification of handcuffs being applied and declaring Mr Bayoh as unconscious. Leg restraints should

be a rapid application, and are typically quicker than handcuffs to apply due to the reduced specific technical alignment required.

20.5 PC Paton's use of a baton during the restraint

20.5.1 The use of the baton across the bicep, with the officer placing his weight through the baton, is not an approved technique. The narrow surface area of a baton will transfer significant force into the muscle and body tissues. In first aid terminology this could create a tourniquet type of manoeuvre. A medically qualified person would need to comment upon the physical impact of this, but from a use of force safety technique point, this is not a practice which I am aware of having been medically risk assessed, and is likely to create a high risk of injury. The application would need to be justified. Staff would be trained to use their own arms/hands upon the bicep area, not using a baton. Officers are taught a tactic which takes the arms to the detainee's back in a 'figure of four' shape. This can be conducted either with the officer's arm or their baton.

20.6 By reference to the enhanced Snapchat footage and stills from same; the evidence (which is in dispute) that Constable Walker (who weighed 25 stones) lay across Mr Bayoh's back

20.6.1 I have viewed the footage[223] and stills. The snapchat footage shows 5 people wearing high-viz jackets around the ground. The quality of the footage does not let me confirm that the item on the ground is a person (Mr Bayoh), or without doubt what position they are in. As explained above it only recorded approximately 5 seconds of the 4 minutes restraint.

20.7 The evidence (from a number of witnesses) that the restraint bore resemblance to a "collapsed rugby scrum"

[223] SBPI-00110

20.7.1 Sometimes, in the initial restraint process, persons can all fall to the ground. The reasonable officer knows that they need to ensure they are not impacting upon the respiratory system of a detainee and ensure, as soon as is practicable, that they move and adopt a safer position. The benefit of a supervisor/controller and safety officer function is essential to co-ordinate staff in the interests of safety.

20.7.2 When a restraint is not co-ordinated, staff work independently without knowledge of what other officers are doing and without knowing if their action(s) are counterproductive. No one formally takes the lead role of supervisor/controller or safety officer. If it is co-ordinated then all staff involved are in sync and understand exactly what is happening and when.

20.7.3 The fact all officers have different accounts of the restraint indicates that it was unco-ordinated, and not managed.

20.8 Whether a reasonable officer would have monitored or arranged to have monitored, Mr Bayoh's breathing during the restraint

20.8.1 Yes, it is standard practice among the UK secure custody establishments to have a member of staff monitor a detained person's vital signs which includes breathing as per basic first aid training – is it normal or not normal breathing? This should be continuous where possible, and regularly in all other circumstances. There is no definition of what 'regularly' means, but first aid training commonly teaches for it to be checked every minute, for up to 10 seconds maximum. The DR ABC principle is what first aid training typically teaches.

20.9 The significance of environmental factors (weather, temperature, Mr Bayoh's state of dress)

20.9.1 Environmental factors would impact upon a casualty's condition, deterioration and recovery. Once the officers decide Mr Bayoh is a non-responsive and non-breathing casualty, basic care should be considered such as protection from the elements. For example, a jacket or blanket below and above Mr Bayoh. Subject to head injury risks, any movement of the head must be carefully considered and cushioning beneath this may not be appropriate. As a non-responsive and non-breathing casualty the theory would be to perform CPR until an ambulance crew arrived and took over.

20.9.2 Removal of all restraints would be basic casualty care. A casualty is likely to be unable to fake unconsciousness when CPR is being performed on them, and if the DR ABC checks have been conducted correctly it would be difficult to still fake unconsciousness.

21. Question 8. Miscellaneous

Insofar as not already explored within the answers to preceding questions, please comment on the following:

- **21.1 Waiting and observing;**
- **21.2 De-escalation: please describe de-escalation techniques and explain what they are designed to achieve and the possible outcomes when such techniques are employed;**
- **21.3 Acute Behavioural Disturbance/Excited Delirium/mental health crisis[224]: please offer a view as to how these matters were defined/taught to officers in 2015; a view as to how these may have been recognised by officers in the field; and whether any of the evidence indicated that Mr Bayoh displayed any signs or symptoms of ABD/ED/mental health crisis (drug induced or otherwise). If so: whether a reasonable officer would have had in mind the possibility of ABD/ED/mental health crisis; at what point in time would this possibility have crossed his mind; and what action would he have taken;**
- **21.4 Positional asphyxia[225]: describe what a reasonable officer would have known of this risk in 2015; describe the steps a reasonable officer would have taken to mitigate the risk of positional asphyxiation (i) if Mr Bayoh were restrained in the prone position and (ii) if he were restrained in the supine position; and**
- **21.5 In what circumstances (if any) do you consider it would be appropriate for an officer to strike a suspect with a vehicle on arrival at a scene? Please refer to the evidence of PC Walker on Day 6, 19 May 2022 page 39, line 22; pages 64 line 23 to page 66 line 8. Please categorise and comment on this proposed**

[224] See Chapter 5 and 21.3 of the Use of Force SOP (PS10933); pages 23-25 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual (PS11538(a))
[225] See Chapter 21 of the Use of Force SOP (PS10933); pages 26 and 27 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual (PS11538(a))

response by an officer. In particular, indicate to what extent, if any, this response would differ to that of a reasonable officer or officers.

21.1 Waiting and Observing

21.1.1 Incidents are categorised initially by the call handler**.** Call handling standards are comparable throughout Scotland, England, Wales and Northern Ireland police services. According to the ACPO National Call Handling Standards:[226]

21.1.1.1 "An emergency contact encompasses circumstances where an incident is reported to the police which is taking place and in which there is, or is likely to be a risk of:

- Danger to life;
- Use, or immediate threat of use, of violence;
- Serious injury to a person; and/or
- Serious damage to property."[227]

21.1.1.2 "The call handler having assessed the risk associated with the call decides the most appropriate call response."[228]

21.1.1.3 "Force policy may require that specified calls (e.g.a complaint) require a certain level of authority for them to be handled."[229]

21.1.1.4 "If a call is graded inappropriately, it can have an impact on every other link in the demand management chain. A unit might be deployed when none should, or one might be deployed too late or not at all."[230]

21.1.1.5 "Dispatch is the 'command and control' function in a force, which assigns and deploys units to incidents based on the information in the incident logs.

---

[226] https://library.college.police.uk/docs/homeoffice/call_handling_standards.pdf
[227] Section 6.2.1.2, page 26
[228] Appendix B, page 129
[229] Appendix B, page 139
[230] Section 8.2.3, page 244

> Traditionally based within BCUs[231], these units are increasingly being rationalised into central locations. With the introduction of Airwave radio, forces will be able to pinpoint officer locations in real-time, and have access to many more talk-groups than are currently available with conventional radio systems."[232]

21.1.2 This reported incident was an emergency, however the ACR staff are required to conduct the initial risk assessment and deployment strategy. Had the incident been declared a firearms incident initially, then unarmed staff would have been clearly directed to wait/observe, and not approach. Had the dog handler been deployed, and knowing he was only approximately 10 minutes away, it is common practice to have uniformed officers wait so that the dog can be deployed first. This prevents the dog biting officers and prevents officers contaminating the scent if they need to track the suspect. The incident appears to have initially been declared a priority 2 incident even though it was endorsed regarding the knife. Then after additional calls were received it was graded a priority 1 disorder incident with knife. This still gave the ACR the option to instruct staff to wait/observe, based upon their initial risk assessment. The categorisation is separate to the deployment control measures.

21.1.3 Although not initially declared a firearms incident, the ACR still proceeded with principles of a firearms incident by establishing availability of the Armed Response Vehicles (ARV) and a dog handler. A 'stay safe' message was still passed. The ACR Inspector stated he was monitoring the incident with consideration to a firearms incident. I am of the opinion that had a firearms unit been in Kirkcaldy, they would have been deployed. Had the dog unit been in Kirkcaldy, I believe they would have been deployed.

21.1.4 In my opinion, unarmed and non-specialist staff should not have been deployed sporadically as they were. This left the officers vulnerable and hindered them from forming a co-ordinated approach, which increased the risk to the public and Mr Bayoh. They

---

[231] BCU – Basic Command Unit
[232] Section 8.3, page 249

should have been deployed to an RV point to observe and muster, for onward deployment with a tactical plan.

21.2 De-escalation: please describe de-escalation techniques and explain what they are designed to achieve and the possible outcomes when such techniques are employed;

21.2.1 De-escalation techniques are more than shouting commands at a person. Understanding basic communication styles for different people is also relevant, as a person in a mental health crisis and/or intoxicated is likely to prove additionally complex for communication.

21.2.2 A person in a mental health crisis is likely to be fearful of the police.

21.2.3 The first police officers arrived at 07:20:23 with the second pair of officers arriving approximately 7 seconds later. If PC Tomlinson's account is correct, within 7 seconds both PC Paton and PC Walker had discharged their CS and PAVA. This did not leave much time for de-escalation.

21.2.4 PC Paton's emergency button was activated by 07:20:42 – approximately 19 seconds after their arrival. This is a very short time span to attempt de-escalation. OST manuals inform police officers that words spoken only account for around 7% of communication, with the majority being from non-verbal communication such as tone of voice, space, body language [233]. Exiting a police vehicle with incapacitant sprays 'at the ready', and shouting commands to go to the ground is likely to communicate police use of force, and not that the officers are there to help a person who may be in a medical crisis.

[233] OST Manual Module 1 Section 4

21.2.5 The arrival of the second patrols used a different policing style of 'mirroring' and keeping distance, whilst trying to speak to Mr Bayoh.

21.2.6 Officers are commonly taught to communicate non-violence and offer help to a person in crisis.

21.2.7 As Mr Bayoh was displaying, at most, level 2 profiled behaviour upon the arrival of PC Paton and PC Walker. His identity had not been confirmed nor was any knife visible. It was possible to attempt a de-escalation approach.

21.2.8 The Police Scotland OST Manual states[234] "It is, therefore, vitally important that officers learn to use appropriate body language which concurs with what they are saying".

21.2.9 Police Scotland do train officers to use the '5 step positive style of tactical communication'. Step 5 is the final option when use of force is decided upon. PC Walker and PC Paton both exited the vehicle indicating they were at level 5, with sprays drawn and immediately giving commands to Mr Bayoh.

21.3 Acute Behavioural Disturbance/Excited Delirium/mental health crisis[235]: please offer a view as to how these matters were defined/taught to officers in 2015; a view as to how these may have been recognised by officers in the field; and whether any of the evidence indicated that Mr Bayoh displayed any signs or symptoms of ABD/ED/mental health crisis (drug induced or otherwise). If so: whether a reasonable officer would have had in mind the possibility of ABD/ED/mental health crisis; at what point in time would this possibility have crossed his mind; and what action would he have taken;

---

[234] Module 1 Section 4
[235] See Chapter 5 and 21.3 of the Use of Force SOP (PS10933); pages 23-25 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual (PS11538(a))

21.3.1 ABD/excited delirium/mental health crisis are terms commonly taught throughout the UK secure sectors. They also feature within the Police Scotland materials. Police officers are not healthcare professionals but are taught to recognise potential risk signs which would include: bizarre behaviour; extreme strength; intoxication and excess temperature. A reasonable officer should be able to consider these factors during an incident and recognise that any suspicion requires the incident to be called a medical emergency and that restraint increases the risk of death.

21.3.2 There are multiple sources of information on this subject throughout the UK secure sector. As Police Scotland sourced their initial information from the College of Policing and the Metropolitan Police (in addition to what other Scottish forces had for the launch of the new Police Scotland in 2013) they would have been provided with the English 2012 'Safer Detention and Handling of Persons in Police Custody' (SDHP) and the College of Policing on-line APP, as these were the national police guidance documents.

21.3.3 The 2012 SDHP guidance book[236] states: "Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening. Excited delirium can be caused by heavy use of certain drugs, typically stimulants, of which cocaine is the most common. The symptoms of excited delirium include:

• A state of high mental and physiological arousal -perceiving others as frightening and dangerous, 'fight or flight reaction';
• Breathing problems;
• Agitation;
• High body temperature and/or sweating – so may try to undress;
• Violence aggression and hostility;
• Insensitivity to pain and incapacitant sprays.

236 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf

People who appear to have this condition should only be restrained in an emergency. They must be taken by ambulance to hospital as soon as the condition is suspected. If no ambulance is immediately available, the individual should be transported to hospital in a suitable police vehicle. It is important that people experiencing excited delirium have their physical health needs assessed prior to any further mental health assessment."[237] This was also comparable in the 2006 SDHP publication.

21.3.4 The College of Policing APP[238] also had a comparable description: "People who are violent and agitated may have an underlying medical reason for their behaviour. If there is any suspicion that the violence stems from a medical condition, the person must be treated as a medical emergency. Whenever possible, the person should be contained rather than restrained until medical assistance can be obtained. The following medical conditions may cause violent, aggressive or changing behaviour and confusion:

- diabetes
- head injury
- epilepsy
- stroke
- infections
- angina and other heart problems
- dehydration (and salt imbalance)
- sickle-cell anaemia
- acute mental illness such as paranoia, hearing voices
- neurological diseases such as dementia and brain injury
- learning difficulties

[237] Section 3.3.5, page 45
[238] https://www.college.police.uk/app/detention-and-custody/detention-and-custody-risk-assessment

There is an increased risk that symptoms of serious illness or injury may go unnoticed where an individual is well known or familiar to police officers and staff. In particular, when dealing with regular detainees who are known substance abusers and/or known to experience mental illness, it should not be assumed that physical or behavioural signs are due to their being under the influence of a substance/mental illness. They may also be caused by substance withdrawal or other medical reasons, any of which can have serious implications for detainee welfare. The symptoms of acute behavioural disturbance (ABD) include:

- a state of high mental and physiological arousal – perceiving others as frightening and dangerous, 'fight or flight' reaction
- breathing problems
- agitation
- high body temperature and/or sweating – so may try to undress
- violence, aggression and hostility
- insensitivity to pain and incapacitant sprays

People who appear to have this condition should be restrained only in an emergency. They must be taken by ambulance to hospital as soon as the condition is suspected. If no ambulance is immediately available, the person should be transported to hospital in a suitable police vehicle. It is important that people experiencing ABD have their physical health needs assessed prior to any further mental health assessment."

21.3.5 The Police Scotland OST Manual stated:

"EXCITED DELIRIUM. WHAT IS EXCITED DELIRIUM?

This is when a subject exhibits violent behaviour in a bizarre and manic way. Excited delirium is a rare form of severe mania which may form part of the spectrum of manic-depressive psychosis and chronic schizophrenia. It is characterised by constant, purposeless, often violent activity with incoherent or meaningless speech and hallucinations with paranoid delusions. Subjects can be dangerous and may die of acute exhaustive mania. Hyperthermia (overheating and profuse sweating, even in cold weather) is often part of this condition.

WHY IS A SUBJECT IN AN EXCITED DELIRIUM STATE OF PARTICULAR CONCERN?

Subjects suffering from excited delirium can die suddenly during, or shortly after, a violent struggle. This could occur whilst at hospital or in custody. HOW IS IT CAUSED? A combination of either drug intoxication, alcohol intoxication or psychiatric illness. Cocaine is the most commonly associated drug with this condition, however other drugs have the potential to induce excited delirium.

HOW DO OFFICERS IDENTIFY A SUBJECT IN A STATE OF EXCITED DELIRIUM?

• They will be abnormally strong

• They will be abnormally tolerant to pain

• Incapacitant sprays may not work on them

• Their skin may be hot

• They may be hallucinating, hiding behind objects, running around or pulling their clothes off

• They may suddenly become subdued or collapse after a bout of extreme violence

ACTIONS TO REDUCE RISK OF DEATH IN RESTRAINED SUBJECT EXHIBITING EXCITED DELIRIUM

• The subject should be placed onto their side, or into a kneeling/seated position as soon as possible

• A subject who has been restrained and exhibits symptoms of excited delirium should be visually and verbally monitored closely

• The subject should not be transported in the prone position, if at all possible

• Officers should be prepared to administer first aid if the subject's condition deteriorates

Any subject exhibiting symptoms of excited delirium should be treated as a MEDICAL EMERGENCY and be assessed immediately at a hospital."[239]

21.3.6 The Faculty of Forensic and Legal Medicine (FFLM) have published guidance[240] for the UK secure sectors on this subject matter, but I am only able to trace their guidance back to January 2016.

---

[239] Module 1 section 12, page 24

[240] 'Acute behavioural disturbance: Guidelines on Management in Police Custody' - https://fflm.ac.uk/wp-content/uploads/2016/02/AcuteBehaveDisturbance_Jan16-1.pdf

21.4 Positional asphyxia[241]: describe what a reasonable officer would have known of this risk in 2015; describe the steps a reasonable officer would have taken to mitigate the risk of positional asphyxiation (i) if Mr Bayoh were restrained in the prone position and (ii) if he were restrained in the supine position; and

21.4.1 Positional asphyxia has been taught to officers for many years. Having joined the police service in February 1990, I was made aware of such risk factors early in my career.

21.4.2 I was teaching staff concerning positional asphyxia, ABD, excited delirium and mental health crisis as part of the 'safer custody' programmes from 2006.

21.4.3 The Police Scotland OST Manual states:
"POSITIONAL ASPHYXIA (RESTRAINT RELATED ASPHYXIA)
Positional Asphyxia (Restraint Related Asphyxia) can occur when a subject is placed in a position which interferes with the ability to breathe. Death can occur rapidly, and it may be the case that a police officer can be found to be liable. The risk factors which contribute to the condition are:
• Subject's body position results in partial or complete airway constriction
• Alcohol or drug intoxication (the major risk factors)
• Inability to escape position
• The subject is prone
• Obesity
• Age
• Stress
• Respiratory muscle fatigue, related to prior violent muscular activity (such as fighting with police officers)
SIGNS AND SYMPTOMS

---

[241] See Chapter 21 of the Use of Force SOP (PS10933); pages 26 and 27 of the OST PowerPoint (PS17208); and Module 1, section 11 of the OST manual (PS11538(a))

Officers should recognise the following symptoms and be prepared to administer emergency first aid:

• Body position restricted to prone, face-down

• Cyanosis (bluish discolouration of the extremities)

• Gurgling / gasping sounds

• An active subject suddenly changes to passive or loud and violent to quiet and tranquil

• Panic

• Verbalising that they cannot breathe.

When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the physiological response to that is accelerated breathing. When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface. If the subject's hands are restrained to the rear breathing ability may be restricted. This must be considered by the officer. The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia. Officers are encouraged to remove the subject from the prone position as soon as possible following restraint. The subject can then breathe without restriction and the officer can still carry out search procedures before executing the safe get-up technique."[242]

21.4.4 A reasonable officer would take into consideration the issue of positional asphyxia and get the restrained person onto their side as soon as possible, then move into seated and standing as soon as possible. They would know not to place any pressure upon the respiratory system – from stomach to throat. This would be applicable whether the person was in prone or supine position, or a side position. Nothing should impede the respiratory function from working effectively.

---

[242] Module 1 section 11, page 23

21.5 In what circumstances (if any) do you consider it would be appropriate for an officer to strike a suspect with a vehicle on arrival at a scene? Please refer to the evidence of PC Walker on Day 6, 19 May 2022 page 39, line 22; pages 64 line 23 to page 66 line 8. Please categorise and comment on this proposed response by an officer. In particular, indicate to what extent, if any, this response would differ to that of a reasonable officer or officers.

21.5.1 There is no reasonable officer response taught which includes striking a person with a police vehicle. However, in recent years the issue has been discussed particularly following the London Bridge terror attacks and in 2017 following the stabbing of PC Keith Palmer outside of the Houses of Parliament. MPS senior officer, Sir Craig Mackey, was in his police vehicle when he witnessed PC Palmer being attacked and killed. I am not aware of any police federation or other official sources which recommend this tactic. (Sir Mackay was previously the Chief Constable of Cumbria Constabulary).

22 Other Information

The Stephen Lawrence Inquiry

22.1 The Stephen Lawrence Inquiry Report[243] although an English publication is available on the internet, and would be relevant for sharing within the National Preventive Mechanism[244] membership, which includes Scotland secure sector agencies. Recommendations included:

22.1.1 Recommendation 45 - First Aid training for all "public contact" police officers (including senior officers) should at once be reviewed and revised to ensure that they have basic skills to apply First Aid. Officers must be taught to "think first aid", and first and foremost "A (Airways), B (Breathing) and C (Circulation)."

22.1.2 Recommendation 46 - “That training in First Aid including refresher training should include testing to recognised and published standards in every Police Service.”

22.1.3 Recommendation 50 - “That police training and practical experience in the field of racism awareness and valuing cultural diversity should regularly be conducted at local level. And that it should be recognised that local minority ethnic communities should be involved in such training and experience.”

22.1.4 Recommendation 52 - “That the Home Office together with Police Services should publish recognised standards of training aims and objectives in the field of racism awareness and valuing cultural diversity.”

22.1.5 Recommendation 53 - “That there should be independent and regular monitoring of training within all Police Services to test both implementation and achievement of such training”

---

243 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

244 See section 8

Christopher Alder death in custody

22.2 Christopher Alder had served in the Parachute Regiment for 6 years, and moved to Hull in 1990. In the early hours of 1st April 1998 he was at a club, socialising. Outside of that club he was assaulted by another man – punched, knocked to the floor and left unconscious. He was taken by ambulance to Hull Royal Infirmary.

22.3 At hospital he displayed unco-operative and aggressive behaviour. A common side effect with a serious head injury.

22.4 The officers who attended the assault scene also attended the hospital, and at the request of the hospital staff, they removed Mr Alder.

22.5 The police officers ended up arresting Mr Alder to 'Prevent a Breach of the Peace'. He was taken in the rear of a police vehicle to the police custody unit at Queen's Gardens police station.

22.6 Mr Alder was carried into custody by the officers as he was found unconscious in the back of the police van. Officers believed he was faking it. (No first aid checks conducted).

22.7 A Custody Sergeant, a PC custody officer, 2 police officers and a 'matron' were present.

22.8 Mr Alder was left, face down, on the floor for approximately 11 minutes. Handcuffs were left on for much of this time. No first aid checks were conducted. Mr Alder remained motionless and unresponsive throughout his time in the custody unit.

22.9 When the officers realised that Mr Alder was not breathing they requested ambulance attendance and made attempts to resuscitate him.

22.10 The inquest commenced in July 2000.

22.11 In February 2006 the Independent Police Complaints Commission (IPCC) published their investigation review.[245]

22.12 The report referred back to the Stephen Lawrence Inquiry and drew some comparisons for learning.

22.13 Learning and recommendations identified for policing included:

22.13.1 Knowledge of positional asphyxia and how it can be avoided;

22.13.2 All staff to be trained in racism awareness and diversity; and

22.13.3 First aid.

22.14 This report was released along with the 2006 Safer Detention and Handling of Persons in Police Custody. As such, the Christopher Alder case became a significant case study for police forces to learn from concerning 'safer custody'.

[245] Report, dated 27th February 2006, of the Review into the events leading up to and following the death of Christopher Alder on 1st April 1998 HC 971-I (publishing.service.gov.uk)

23 Expert Witness overall summary

23.1 Incidents must be graded by the ACR concerning risk and priority response. In response to a high threat incident which may justify the deployment of Authorised Firearms Officers (AFOs) in ARVs, and/or police dogs; or recognise the issue of violent/deranged persons, the following safer practice could have been considered:

23.1.1 The ACR Inspector maintains the role of initial commander for the incident due to it being a high-risk incident. Two of the three armed policing SOP criteria could be considered regarding “other potentially lethal weapon” and “otherwise so dangerous”;

23.1.2 Regardless of whether the incident was declared a firearms incident or not, it was believed to be high-risk with a large man wielding a knife, and unarmed officers being deployed. Enquiries were commenced to deploy the ARV and dog handler which is common for high-risk incidents. Two dog handlers were contacted and one unit stated to the Inquiry that he could have been at the scene in 10 to 15 minutes. The incident could have been managed by the deployment of the dog unit and it was not an unreasonable amount of time to wait if no member of the public was directly at risk. Dogs are specifically trained to deal with violent people;

23.1.3 Unarmed officers should have been deployed to an RV point to muster and observe until the tactical plan was agreed, and a managed and controlled intervention agreed as the tactical plan. Unarmed officers should not attend sporadically as they did;

23.1.4 Medical attendance from the outset should have been considered. Head strike information should have been passed to ACR to pass to ambulance control.

23.1.5 Identity of subject needed to be confirmed;

23.1.6 Possession of knife needed to be confirmed;

23.1.7 Consideration of medical and/or mental health crisis needed confirmed/discounted;

23.1.8 Staff should have deployed as a team, not sporadically as occurred. Minimal use of force to achieve the objective should have been the plan;

23.1.9 Any use of force should be the minimum required to gain control quickly and place the detainee in a safe position. Throughout the use of force it should be co-ordinated and managed by a controller/safety officer. Officers should be acting as a manual handling team under direction of the controller/safety officer;

23.1.10 During the restraint a detainee's vital signs such as airway, breathing and circulation need to be manually assessed by a Constable. This includes assessing breathing as being either 'normal' or 'not normal'. Breathing/not breathing is outdated first aid. The DR ABC should be used.

23.1.11 Whether initially in prone or supine, the person needs to be moved out of it as soon as possible into a side lateral position, then seated and then standing;

23.1.12 Early recognition of a potential medical emergency needs to be recognised and an ambulance requested;

23.1.13 All restraints should be removed as soon as a person is non-responsive, or a medical emergency is declared;

23.1.14 No officer should lay over the torso of a restrained person, whether in prone or supine. This will interfere with breathing;

23.1.15 Strikes to the head should be immediately declared as high-risk, and request for ambulance attendance. Ambulance crews should be informed of these risk factors, as this may affect attendance response time;

23.1.16 CPR should not be delayed. If the person is unresponsive and not breathing 'normally', CPR should be commenced.

23.2 Concerning the timeline of the entire incident.

23.2.1 Officers arrived at scene at 07:20:23, with the second patrol arriving 7 seconds later. By 07:21:38 Mr Bayoh is reported as being secure on the ground. During this 75 seconds it is reported that 3 officers had discharged various quantities of incapacitant spray, and Mr Bayoh had been struck numerous times by police baton, including four baton strikes to the head by PC Tomlinson and two punches to the face by PC Walker[246]. PC Smith informs Control that Mr Bayoh is secure and also that PC Short was punched to the head. This was an opportunity to request an ambulance for Mr Bayoh due to the numerous risk factors he has presented with and the use of force used against him.

23.2.2 At 07:23:34 an ambulance was requested for PC Short by acting Sergeant Maxwell due to her receiving the punch to her head. An ambulance should also have been requested for Mr Bayoh.

23.2.3 It was 07:25:17 when an ambulance was requested for Mr Bayoh after he became unconscious and unresponsive. The need for an ambulance for Mr Bayoh should have been recognised earlier due to the risk warning signs which officers were confronted with, and the fact he had been struck to the head on several occasions, even before he became unresponsive.

23.2.4 Unresponsive and not breathing 'normally' are the principles for starting CPR. Formal observations were not employed as part of the restraint procedure. DR ABC should have commenced from Mr Bayoh first being declared as 'secure', and regularly conducted. Breathing checks as per DR ABC training may have identified abnormal breathing before Mr Bayoh was declared as not breathing. Officers appear to identify that he went from normal breathing to not breathing, without recognition of any decline. I am not a healthcare professional so cannot comment on whether there was likely to be signs of abnormal

[246] Please see report para 18.2.12

breathing prior to no breathing. CPR should be commenced as soon as abnormal breathing is identified, if they are also unresponsive.

Experts Declaration & Statement of Truth

I understand that my overriding duty is to the court and I have complied with that duty. I am aware of the requirements of the Civil Procedure Rules Part 35, its practice direction and the CJC Guidance for the instruction of experts in civil claims.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

31st October 2022

Appendix A – Source Documents

Police Scotland critical incident management national guidance https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.scotland.police.uk%2Fspa-media%2Fvrjcos44%2Fpublication-scheme-critical-incident-management-ng-v1-00.doc&wdOrigin=BROWSELINK

GMP 2017 Incident response policy example policy https://www.gmp.police.uk/SysSiteAssets/foi-media/greater-manchester/policies/incident-response-policy-v1.3-july-2017-redacted.pdf

ACPO management and deployment of armed officers 2011 guidance https://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations%20FOI/2012/093%2012%20%20Att%2001%20of%201%20Management%20Command%20and%20delpyment%20of%20Firearms%20Officers.pdf

College of Policing public order APP https://www.college.police.uk/app/public-order

ACPO Command & Control National Guidance 2009 https://www.effectivecommand.org/docs/UK/NPIA%20ACPO%20Guidance%20on%20Command%20&%20Control%20(2009).pdf

Scottish Guidance: Responding to emergencies 2017 https://ready.scot/sites/default/files/2020-09/preparing-scotland-responding-to-emergencies_0.pdf

Responding to emergencies Scotland https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/responding-emergencies/response

Specially Trained Officers Standard Operating Procedure Police Scotland 2020 version 3 https://www.scotland.police.uk/spa-media/sc4gwztv/specially-trained-officers-sop-v3-00-pub-scheme.pdf

ACPO 2006 Police National Mobilisation Plan

Police Scotland Critical Incident Management SOP

National Call Handling Standards
https://library.college.police.uk/docs/homeoffice/call_handling_standards.pdf

Basic Principles on the Use of Force and Firearms by Law Enforcement Officials Adopted 1990 https://www.ohchr.org/en/instruments-mechanisms/instruments/basic-principles-use-force-and-firearms-law-enforcement

Code of Practice on Armed Policing and Police use of Less Lethal Weapons January 2020 https://library.college.police.uk/docs/appref/CCS207-CCS0120853800-001-Code-of-Practice-on-Armed-Policing.pdf

Police Scotland Contact, Command & Control (C3) Division National Guidance

Police Scotland use of force manual

Police Scotland Standard Operating Procedures custody

Police Scotland Standard Operating Procedures use of force

Escalation of trauma chart p84 Use of force SOP red/green chart

Monadnock baton strike red/yellow/green chart

Royal College of Emergency Medicine (2016) Guidelines for the Management of Excited

Delirium/Acute Behavioural Disturbance. London: RCEM

Police Scotland NDM powerpoint slides & College of Policing NDM authorised professional practice https://www.college.police.uk/app/national-decision-model

Civil Contingencies Act Scotland report https://www.audit-scotland.gov.uk/uploads/docs/report/2009/nr_090806_civil_contingencies.pdf#:~:text=T

he%20Civil%20Contingencies%20Act%202004%20%28referred%20to%20as,UK.%20The%20Contingency%20Planning%20%28Scotland%29%20Regulations%202005%20describe

ACC Bernard Higgins digital recording 2015. 3 minutes 40 seconds

Police Scotland critical incident management national guidance.

McPherson public inquiry – The Stephen Lawrence Enquiry https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

Christopher Alder Inquiry

Police Complaints Authority Policing ABD 2002

David Bennett Inquiry Report

Mental health crisis care: physical restraint in crisis A report on physical restraint in hospital settings in England June 2013 **https://www.mind.org.uk/media-a/4378/physical_restraint_final_web_version.pdf**

The Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 25 October 2018 https://www.ecoi.net/en/file/local/2018210/2019-29-inf-eng.docx.pdf

The first NPM annual report, which is available https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2015/06/NPM-1st-Annual-Report-2009-10.pdf

The NPM published the 5th annual report for 2013 to 2014. This included the publication of the Independent Advisory Panel on Deaths in Custody: Common principles of safer restraint (see appendix). https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2015/05/NPM-5th-Annual-Report-2013-14.pdf

Police Scotland Contact, Command & Control (C3) Division National Guidance document.
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.scotland.police.uk%2Fspa-media%2Fgwep0iv0%2Fcontact-command-control-c3-division-national-guidance.doc&wdOrigin=BROWSELINK This is version 2, dated 2021

The IPCC report
https://webarchive.nationalarchives.gov.uk/ukgwa/20170914112706/http:/www.ipcc.gov.uk/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

Scottish Police 2013 safety manual and the College of Policing England & Wales Officer safety manual

The 2017 report of the independent review of deaths and serious incidents in police custody by Rt. Hon Dame Elish Angiolini DBW QC
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

Home Affairs Committee
https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

Head injuries are covered in several leading UK wide publications which include:

- The Faculty of Forensic and Legal Medicine (FFLM) https://fflm.ac.uk/wp-content/uploads/2019/12/Head-injury-warning-Advice-to-custody-officers-gaolers-detention-officers-Prof-J-Payne-James-and-Prof-P-Marks-Dec-2019.pdf
- The National Institute for Health and Care Excellence (NICE) Head Injury assessment and early management https://www.nice.org.uk/Guidance/CG176

The FFLM produce guidance concerning ABD.
https://library.college.police.uk/docs/appref/Acute-behavioural-disturbance_Apr19.pdf

2011 review by the Independent Advisory Panel (IAP) on deaths in custody

Police Scotland NDM powerpoint slides & College of Policing NDM authorised professional practice https://www.college.police.uk/app/national-decision-model

McPherson public inquiry – The Stephen Lawrence Enquiry https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

The IPCC report https://webarchive.nationalarchives.gov.uk/ukgwa/20170914112706/http:/www.ipcc.gov.uk/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

Scottish Police 2013 safety manual and the College of Policing England & Wales Officer safety manual

Home Affairs Committee https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

Head injuries are covered in several leading UK wide publications which include:

- The Faculty of Forensic and Legal Medicine (FFLM) https://fflm.ac.uk/wp-content/uploads/2019/12/Head-injury-warning-Advice-to-custody-officers-gaolers-detention-officers-Prof-J-Payne-James-and-Prof-P-Marks-Dec-2019.pdf
- The National Institute for Health and Care Excellence (NICE) Head Injury assessment and early management https://www.nice.org.uk/Guidance/CG176

The FFLM produce guidance concerning ABD. https://library.college.police.uk/docs/appref/Acute-behavioural-disturbance_Apr19.pdf

Royal College of Emergency Medicine acute behavioural disturbance guidelines for police custody

Delirium: prevention, diagnosis and management Clinical guideline Published: 28 July 2010 www.nice.org.uk/guidance/cg103 https://www.nice.org.uk/guidance/cg103/resources/delirium-prevention-diagnosis-and-management-pdf-35109327290821

College of emergency medicine ABD guidance valid to 2016 file:///C:/Users/total/Dropbox/Total%20Train%20MASTER%20COPY%2005%20June%202018/custody/RCEM_ABD_250416.pdf

FFLM ABD guidance https://fflm.ac.uk/wp-content/uploads/2022/10/ABD-Guidelines-on-Management-in-Police-Custody-Oct-2022.pdf

Report, dated 27th February 2006, of the Review into the events leading up to and following the death of Christopher Alder on 1st April 1998 HC 971-I (publishing.service.gov.uk)

Acute behavioural disturbance: Guidelines on Management in Police Custody' -

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf

https://library.college.police.uk/docs/homeoffice/call_handling_standards.pdf

https://www.equalityhumanrights.com/en/publication-download/human-rights-framework-restraint

Forensic science and medicine. D.L. Ross & T.C. Chan. 'Sudden Deaths in Custody' 2006

Medicine, Science and Law. 'Sudden Death during Restraint: Do some Positions affect Lung Function' April 2008 pages 137-141 https://pubmed.ncbi.nlm.nih.gov/18533573/

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/543806/DSO_07-2016_Use_of_Restraints.pdf ;

[2012] EWHC 1804 (Admin) FGP and SERCO PLC;

https://vdocuments.net/resuscitation-guidelines-2010.html

https://www.mind.org.uk/media-a/4378/physical_restraint_final_web_version.pdf

The UK Independent Advisory Panel and the 2004 Metropolitan Police review

Sickle Cell and Deaths in Custody. ISBN 18617711150 published by Whiting & Birch Ltd, Forest Hill, London

https://webarchive.nationalarchives.gov.uk/ukgwa/20170914112706/http:/www.ipcc.gov.uk/Documents/research_stats/Deaths_In_Custody_Report_0811.pdf

https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

[1] http://policeauthority.org/Metropolitan/downloads/committees/mpa/mpa-040930-11-appendix01.pdf Section 5.2
[1] https://mentalhealthpartnerships.com/resource/independent-commission-on-mental-health-and-policing-report/

https://www.nice.org.uk/Guidance/CG176

https://fflm.ac.uk/wp-content/uploads/2020/10/ARCHIVED-Factsheet-Head-Injury-Warning-July-2011.pdf

Materials to be provided to Joanne Caffrey

Witnesses called to give Evidence

1. **Mark Degiovanni**

- Transcript Day 3 (12 May 2022)
- Advanced Laser Imaging – 12/05/22 am - YouTube
- Advanced Laser Imaging – 12/05/22 pm - YouTube

2. **Inspector Steven Stewart**

- PIRC-00395: Statement dated 9 October 2015
- SBPI-00084: Statement dated 17 March 2022
- Transcript Day 5 (17 May 2022
- Transcript Day 6 (19 May 2022)
- Evidence from Kara Ferrier and Inspector Steven Stewart (pm) - 17/05/2022 - YouTube
- Evidence from Inspector Steven Stewart and PC Walker (am) - 19/05/2022 - YouTube

3. **PC Colin Gill**

- PIRC-00507: Statement dated 14 February 2018
- SBPI-00083: Statement dated 18 March 2022
- PIRC-03838: Disclosed version of COPFS-00190 (as referred to in SBPI-00083).
- Transcript Day 5 (17 May 2022)
- Evidence from Alan Pearson, Simon Rowe, Linda Limbert and Colin Gill (am) - 17/05/2022 - YouTube

4. PC Kara Ferrier

- PS-09751: Statement dated 28 July 2015
- SBPI-00033: Statement dated 28 February 2022
- Transcript Day 5 (17 May 2022)
- Evidence from Kara Ferrier and Inspector Steven Stewart (pm) - 17/05/2022 - YouTube

5. PC Alan Paton

- PIRC-00262: Statement dated 4 May 2015
- SBPI-00054: Rule 8 Request dated 1 April 2022
- SBPI-00081: Statement dated 5 May 2022
- Transcript Day 20 (21 June 2022)
- Evidence from Alan Paton (am) – 21/06/2022 - YouTube
- Evidence from Alan Paton (pm) - 21/06/2022 | Sheku Bayoh Inquiry

6. PC Craig Walker

- PIRC-00264: Statement dated 4 June 2015
- PIRC-00265: Undated statement
- SBPI-00060: Rule 8 Request dated 31 March 2022
- SBPI-00039: Statement dated 7 April 2022
- COPFS-05965: Document referred to in SBPI-00039
- PIRC-00263: Document referred to in SBPI-00039
- PIRC-00266: Document referred to in SBPI-00039
- PIRC-00278: Document referred to in SBPI-00039
- PIRC-00274: Document referred to in SBPI-00039
- PIRC-00273: Document referred to in SBPI-00039
- Transcript Day 6 (19 May 2022)
- Transcript Day 7 (20 May 2022)
- Evidence from PC Walker (pm) - 19/05/2022 - YouTube
- Evidence from PC Craig Walker (am) - 20/05/2022 | Sheku Bayoh Inquiry
- Evidence from PC Walker (pm) - 20/05/2022 - YouTube

7. PC Ashley Tomlinson

- PIRC-00263: Statement dated 4 June 2015
- SBPI-00052: Rule 8 Request dated 1 April 2022
- SBPI-00043: Statement dated 13 April 2022
- Transcript Day 9 (25 May 2022)
- Transcript Day 10 (26 May 2022)

- Evidence from PC Tomlinson (pm) - 25/05/2022 - YouTube
- Evidence from PC Tomlinson (am) - 26/05/2022 - YouTube
- Evidence from Akhtar Ali and PC Ashley Tomlinson (pm) - 26/05/2022 | Sheku Bayoh Inquiry

8. PC Nicole Short

- PIRC-00253: Statement dated 13 May 2015
- PIRC-00254: Statement dated 4 June 2015
- PIRC-00255: Statement dated 9 June 2015
- PIRC-00256: Statement dated 16 June 2015
- SBPI-00053: Rule 8 Request dated 31 March 2022
- SBPI-00041: Statement dated 7 April 2022
- PIRC-01160: Document referred to in SBPI-00041
- PIRC-01163: Document referred to in SBPI-00041
- PIRC-00259: Document referred to in SBPI-00041
- PIRC-01456: Document referred to in SBPI-00041
- PIRC-01457: Document referred to in SBPI-00041
- PIRC-01405: Document referred to in SBPI-00041
- Transcript Day 8 (24 May 2022)
- Evidence from Nicole Short (am) - 24/05/2022 | Sheku Bayoh Inquiry
- Evidence from Nicole Short (pm) - 24/05/2022 | Sheku Bayoh Inquiry

9. PC Kayleigh Good

- PIRC-00274: Statement dated 4 June 2015
- PIRC-00275: Statement dated 12 January 2017
- SBPI-00049: Rule 8 Request dated 5 April 2022
- SBPI-00040: Statement dated 13 April 2022
- Transcript Day 12 (31 May 2022)
- Evidence from Kevin Nelson and PC Kayleigh Good (pm) - 31/05/2022 | Sheku Bayoh Inquiry

10. PC Alan Smith

- PIRC-00278: Statement dated 11 June 2015
- SBPI-00055: Rule 8 Request dated 5 April 2022
- SBPI-00042: Statement dated 13 April 2022
- Transcript Day 11 (27 May 2022)
- Evidence from PC Smith (am) – 27/05/2022 - YouTube
- Evidence from PC Alan Smith (pm) - 27/05/2022 | Sheku Bayoh Inquiry

11. PC Daniel Gibson

- PIRC-00258: Statement dated 4 June 2015
- SBPI-00051: Rule 8 Request dated 6 April 2022
- SBPI-00045: Statement dated 15 April 2022
- PIRC-03374: Document referred to in SBPI-00045
- Transcript Day 13 (1 June 2022)

- Evidence from Dr Pickering and PC Gibson (am) – 01/06/2022 - YouTube
- Evidence from PC Gibson (pm) – 01/06/2022 - YouTube

12. PC James McDonough

- PIRC-00273: Statement dated 4 June 2015
- SBPI-00050: Rule 8 Request dated 6 April 2022
- SBPI-00063: Statement dated 1 May 2022
- Transcript Day 14 (7 June 2022)
- Evidence from PC McDonough (am) – 07/06/2022 - YouTube

13. Sgt Scott Maxwell

- PIRC-00266: Statement dated 4 June 2015
- PIRC-00267: Undated statement
- SBPI-00056: Rule 8 Request dated 7 April 2022
- SBPI-00044: Statement dated 21 April 2022
- Transcript Day 14 (7 June 2022)
- Transcript Day 15 (8 June 2022)
- Evidence from Sergeant Scott Maxwell (pm) – 07/06/2022 - YouTube
- Evidence from Sergeant Maxwell and Ashley Wyse (am) – 08/06/2022 - YouTube
- Evidence from Sergeant Maxwell and Ashley Wyse (pm) – 08/06/2022 - YouTube

14. DC Samantha Davidson

- PS-00379: Statement dated 4 May 2015
- PIRC-00184: Statement dated 29 May 2015
- PIRC-00185: Statement dated 2 June 2015
- SBPI-00038: Statement dated 9 March 2022
- Transcript Day 17 (10 June 2022)
- Evidence from Dr Crawford, Jane Combe and DI Davidson (am) – 10/06/2022 - YouTube
- Evidence from DI Davidson and DC Bruce (pm) – 10/06/2022 - YouTube

15. Kevin Nelson

- COPFS-00055: Statement dated 6 October 2016
- PIRC-00019: Statement dated 5 May 2015
- PIRC-00020: Statement dated 26 August 2015
- SBPI-00014: Statement dated 22 December 2021
- SBPI-00015: Annotated map
- Transcript Day 12 (31 May 2022)
- Evidence from Kevin Nelson (am) - 31/05/2022 | Sheku Bayoh Inquiry
- Evidence from Kevin Nelson and PC Kayleigh Good (pm) - 31/05/2022 | Sheku Bayoh Inquiry

16. Ashley Wyse

- COPFS-00046: Statement dated 2 November 2016
- COPFS-00047: Statement dated 4 October 2016

- PIRC-00043: Statement dated 5 May 2015
- PIRC-00044: Statement dated 3 May 2015
- PIRC-00045: Statement dated 25 August 2015
- SBPI-00132: Statement dated 8 March 2022
- PIRC-04247: Document referred to in SBPI-00132
- PIRC-04248: Document referred to in SBPI-00132
- PIRC-04249: Document referred to in SBPI-00132
- PIRC-03450: Document referred to in SBPI-00132
- Transcript Day 15 (8 June 2022)
- Evidence from Sergeant Maxwell and Ashley Wyse (am) – 08/06/2022 - YouTube
- Evidence from Sergeant Maxwell and Ashley Wyse (pm) – 08/06/2022 - YouTube

17. Christopher Fenton

- COPFS-00048: Statement dated 11 October 2016
- PIRC-00251: Statement dated 17 June 2015
- SBPI-00010: Annotated map
- SBPI-00011: Statement dated 10 December 2021
- Transcript Day 21 (22 June 2022)
- Evidence from Christopher Fenton and David Taylor (am) – 22/06/2022 - YouTube

Witnesses not called to give evidence

1. Hazel Sinclair

- COPFS-00053: Statement dated 6 October 2016
- PIRC-00056: Statement dated 3 May 2015
- PIRC-00057: Statement dated 7 May 2015
- SBPI-00023: Statement dated 15 December 2021

2. Abdeloouhab Guessoum

- COPFS-00042: Statement dated 23 November
- PIRC-00075: Statement dated 8 May 2015

3. Daniel Robinson

- COPFS-00049: Statement dated 12 October 2016
- PIRC-00117: Statement dated 14 May 2015

4. Sean Mullen

- COPFS-00057: Statement dated 20 December 2017
- PIRC-00120: Statement dated 14 May 2015

Officer safety training

1. **PC Stephen Boyd**

- PIRC-00497: Statement dated 28 September 2017
- SBPI-00116: Statement dated 10 March 2022

2. **PC Richard Wood**

- PIRC-00498: Statement dated 24 January 2018
- PIRC-00499: Statement dated 27 February 2018
- PIRC-00500: Statement dated 13 March 2018

3. **PC Alasdair Shaw**

- PIRC-00501: Statement dated 5 February 2018

4. **David Agnew**

- COPFS-00060: Statement dated 22 February 2018
- PIRC-00503: Statement dated 6 February 2018
- PIRC-00504: Statement dated 13 March 2018
- SBPI-00109: Statement dated 18 February 2022

5. **Insp James Young**

- PIRC-00388: Statement dated 14 September 2015
- PIRC-00389: Statement dated 11 December 2017
- PIRC-00390: Statement dated 12 January 2018
- SBPI-00153: Statement dated 21 March 2022

6. **PC Gary Wood**

- SBPI-00108: Statement dated 28 March 2022
- PIRC-01399: Document referred to in SBPI-00108

7. **PC Graham Patience**

- PIRC-00502: Statement dated 7 February 2018

8. **PC Adam Dawson**

- PIRC-00514: Statement dated 19 March 2018

Multimedia/ALI

1. SBPI-00046: Evidence video timeline

2. SBPI-00104: Scene overview

3. 3D Reconstruction of Scene
   - SBPI-00127
   - SBPI-00129

4. Advanced Laser Imaging Digital Reconstruction Stills

5. SBPI-00047: Combined audio and video timeline

6. All enhanced Snapchat footage
- PIRC-03368
- PIRC-03369
- PIRC-03370
- PIRC-03371
- SBPI-00110

7. PIRC-03374: Photos marked up by Samantha Davidson

Training materials and SOPs

1. PS-10933: Use of Force SOP

2. PS-10939: Fife Constabulary Use of Force SOP

3. PS-11344: Police Dogs SOP

4. PS-10985: Armed Policing Operations SOP

5. PS-11535: Health and Safety SOP

6. Care and Welfare of Persons in Custody SOP including appendices
- PS-11014
- PS-17915
- PS-17918

7. PS-11003: Critical Incident Management SOP

8. PS-11538(a): Probationer Training OST course manual

9. PS-17208: Police Scotland Officer Safety Training Powerpoint.

10. PS-13182: Police Scotland National Decision Making Model

11. PS-12954: Police Scotland PAVA Guidance Document

12. PS-18270: Police Scotland CS Spray Deployment Generic Risk Assessment

13. PS-17200: Police Scotland National Officer Safety Instructor Course Notes

Miscellaneous

1. PIRC-01445: Final post-mortem report

2. Threat level documents

- PS09749
- PS01314
- PS01315
- PS01317
- PS01319

3. Part 35 of Civil Procedure Rules

- PART 35 - EXPERTS AND ASSESSORS - Civil Procedure Rules (justice.gov.uk)

4. Position statement - Chief Constable

5. SBPI-00002: Hearing 1 Law & Practice Note

6. Officer Training Logs

- PS-00051: Nicole Short
- PS-00055: Alan Paton
- PS-00057: Alan Smith
- PS-00059: Ashley Tomlinson
- PS-00061: Craig Walker
- PS-00062: Daniel Gibson
- PS-00063: James McDonough
- PS-00066: Kayleigh Good
- PS-00067: Scott Maxwell

7. STORM Logs

- PS-00231
- PS-00232

8. SBPI-00082: Transcript of 999 calls

9. Scott Masterton statements
- PIRC-00331: Statement dated 6 July 2015
- SBPI-00067: Statement dated 11 March 2022

10. PS-12234: Scottish Police Authority HR & Remuneration Committee ‘Police Officer & Police Staff Assaults – Summary Paper’

Appendix B: The National Decision-Making Model (NDM)

https://www.app.college.police.uk/app-content/national-decision-model/?s=

Police decision making is often complex. Decisions are required in difficult circumstances and are often made based on incomplete or contradictory information. In addition, police officers and police staff are sometimes required to make decisions in circumstances where those involved deliberately mislead or try to mislead them. It is, therefore, not surprising that sometimes the decision does not achieve the best outcome.

To help everyone in policing make decisions and to provide a framework in which decisions can be examined and challenged, both at the time and afterwards, the police service has adopted a single, national decision model (NDM).

The model has at its centre the Code of Ethics, as the touchstone for all decision making. Using the model encourages officers and staff to act in accordance with the Code and use their discretion where appropriate. It also reduces risk aversion and weighs the balance of resourcing against demand, threat and risk.

Decision makers will receive the support of their organisation in instances where it can be shown that their decisions were assessed and managed reasonably in the circumstances existing at the time. This support applies even where harm results from those decisions and actions.

A full index of National Decision Model APP is available.

National Decision Model APP consolidates information from a number of decommissioned documents. For a full list of titles click here.

The NDM is specific to policing. The Joint Decision Model (JDM) has been developed for use when officers and staff are making decisions jointly with other partner agencies. It is based on the NDM and is included within the Joint Emergency Services Interoperability Programme (JESIP).

The National Decision Model (NDM) is suitable for all decisions and should be used by everyone in policing. It can be applied:

- to spontaneous incidents or planned operations
- by an individual or team of people
- to both operational and non-operational situations.

Decision makers can use the NDM to structure a rationale of what they did during an incident and why.

Managers and others can use it to review decisions and actions, and promote learning.

In a fast-moving incident, the police service recognises that it may not always be possible to segregate thinking or response according to each phase of the model. In such cases, the main priority of decision makers is to keep in mind their overarching mission to act with integrity to protect and serve the public.

The model

The NDM has six key elements. Each component provides the user with an area for focus and consideration. The element that binds the model together is the Code of Ethics at the centre.

Code of Ethics

1. The NDM puts the Code of Ethics at the heart of all police decision making. This distinguishes the NDM from other decision-making models and recognises the need for all police decisions to be consistent with the principles and standards of behaviour set out in the Code.

Policing principles

2. The policing principles originate from the Principles of Public Life developed by the Committee on Standards in Public Life in 1995. The Code of Ethics includes the

principles of ‘fairness’ and ‘respect’ as research has shown these to be crucial to maintaining and enhancing public confidence in policing.

3. **Accountability** – You are answerable for your decisions, actions and omissions

4. **Fairness** – You treat people fairly

5. **Honesty** – You are truthful and trustworthy

6. **Integrity** – You always do the right thing

7. **Leadership** – You lead by good example

8. **Objectivity** – You make choices on evidence and your best professional judgement

9. **Openness** – You are open and transparent in your actions and decisions

10. **Respect** – You treat everyone with respect

11. **Selflessness** – You act in the public interest

Standards of professional behaviour

12. These standards originate from the Police (Conduct) Regulations 2012 (for police officers) and the Police Staff Council Joint Circular 54 (for police staff). They reflect the expectations that the College of Policing and the public have of the behaviour of those working in policing.

13. **Honesty and integrity** — I will be honest and act with integrity at all times, and will not compromise or abuse my position.
14. **Authority, respect and courtesy** — I will act with self-control and tolerance, treating members of the public and colleagues with respect and courtesy. I will use my powers and authority lawfully and proportionately, and will respect the rights of all individuals.
15. **Equality and diversity** — I will act with fairness and impartiality. I will not discriminate unlawfully or unfairly.
16. **Use of force** — I will only use force as part of my role and responsibilities, and only to the extent that it is necessary, proportionate and reasonable in all the circumstances.
17. **Orders and instructions** — I will, as a police officer, give and carry out lawful orders only, and will abide by police regulations. I will give reasonable instructions only, and will follow all reasonable instructions.
18. **Duties and responsibilities** — I will be diligent in the exercise of my duties and responsibilities.
19. **Confidentiality** — I will treat information with respect, and access or disclose it only in the proper course of my duties.
20. **Fitness for work** — I will ensure, when on duty or at work, that I am fit to carry out my responsibilities.

21. **Conduct** — I will behave in a manner, whether on or off duty, which does not bring discredit on the police service or undermine public confidence in policing.
22. **Challenging and reporting improper behaviour** — I will report, challenge or take action against the conduct of colleagues which has fallen below the standards of professional behaviour.

Six key elements (CIAPOAR)

23. The mnemonic CIAPOAR can help users to remember the six key elements of the NDM. It also acts as an aide-memoire in aspects of decision making.

24. **Code of Ethics** – Principles and standards of professional behaviour

25. **Information** – Gather information and intelligence

26. **Assessment** – Assess threat and risk and develop a working strategy

27. **Powers and policy** – Consider powers and policy

28. **Options** – Identify options and contingencies

29. **Action and review** – Take action and review what happened

30.

Code of Ethics

31. The Code of Ethics sets out the policing principles that members of the police service are expected to uphold and the standards of behaviour they are expected to

meet. Many forces have their own values statements which are complementary to the Code of Ethics.

32. Throughout a situation, decision makers should ask themselves:

- Is what I am considering consistent with the Code of Ethics?
- What would the victim or community affected expect of me in this situation?
- What does the police service expect of me in this situation?
- Is this action or decision likely to reflect positively on my professionalism and policing generally?
- Could I explain my action or decision in public?

Information – gather information and intelligence

33. During this stage the decision maker defines the situation (ie, defines what is happening or has happened) and clarifies matters relating to any initial information and intelligence.

34. Decision makers (ie, potentially everyone in policing) could ask themselves:

- What is happening?
- What do I know so far?
- What do I not know?
- What further information (or intelligence) do I want/need at this moment?

Assessment – assess threat and risk and develop a working strategy

35. This analytical stage involves assessing the situation, including any specific threat, the risk of harm and the potential for benefits. Among other things decision makers should consider the objectives of preventing discrimination, promoting good relations and fostering equal opportunities.

36. Develop a working strategy to guide subsequent stages by asking:

- Do I need to take action immediately?
- Do I need to seek more information?
- What could go wrong (and what could go well)?
- What is causing the situation?
- How probable is the risk of harm?
- How serious would it be?
- Is that level of risk acceptable?
- Is this a situation for the police alone to deal with?
- Am I the appropriate person to deal with this?
- What am I trying to achieve?
- Will my action resolve the situation?

Powers and policy – consider powers and policy

37. This stage involves considering the powers, policies and legislation that could apply in this particular situation.

38. Decision makers could ask themselves:

- What police powers might be required?
- Is there any national guidance covering this type of situation?
- Do any local organisational policies or guidelines apply?
- What legislation might apply?
- Is there any research evidence?

39. It may be reasonable to act outside policy as long as there is a good rationale for doing so.

Options – identify options and contingencies

40. This stage involves considering the different ways to make a particular decision (or resolve a situation) with the least risk of harm.

41. Decision makers should consider:

- the options that are open
- the immediacy of any threat
- the limits of information to hand
- the amount of time available
- the available resources and support
- their own knowledge, experience and skills
- the impact of potential action on the situation and the public
- what action to take if things do not happen as anticipated.

42. If decision makers have to account for their decisions, will they be able to say they were:

- proportionate, legitimate, necessary and ethical?
- reasonable in the circumstances facing them at the time?

Action and review – take action and review what happened

43. This stage has two distinct steps. At the action step, decision makers are required to make and implement appropriate decisions. The review step requires decision makers to review and reflect on what happened once an incident is over.

Action

44. Respond:

- Implement the option you have selected.
- Does anyone else need to know what you have decided?

45. Record:

- If you think it is appropriate, record what you did and why.

46. Monitor:

- What happened as a result of your decision?
- Was it what you wanted or expected to happen?

47. If the incident is continuing, go through the NDM again as necessary.

Review

48. If the incident is over, review your decisions, using the NDM. What lessons can you take from how things turned out and what might you do differently next time? If appropriate, evaluate the impact of the decision on outcomes.

Recording decision making

49. Decision makers are accountable for their decisions and must be prepared to provide a rationale for what they did and why. In some circumstances the need to document decisions is prescribed by statute, required by organisational strategies, policies or local practices, or left to the decision maker's discretion.

50. Whatever the circumstances, the police service recognises that it is impossible to record every single decision and that not all decisions need to be recorded. In most instances professional judgement should guide officers on whether or not to record the rationale, as well as the nature and extent of any explanation.

51. The record should be proportionate to the seriousness of the situation or incident, particularly if this involves a risk of harm to a person.

52. Decision makers may find the mnemonic CIAPOAR provides a useful structure for recording the rationale behind their decisions (eg, brief notes in notebooks against individual letters). Any notes should be proportionate to the situation.

53. **C** – the principles and standards of the Code of Ethics considered during decision making

54. **I** – information and intelligence known about the situation

55. **A** – how it was assessed and what the working strategy was

56. **P** – any powers, policies, legislation that applied

57. **O** – the main options considered

58. **A** – the decision made or action taken

59. **R** – the resulting outcome

60. CIAPOAR may also be useful when describing or reviewing a decision.

Reviewing decision making

61. The NDM can be useful for examining decisions made and action taken, whether by a supervisor or during an informal investigation or a formal inquiry.

62. Code of Ethics

- How were the principles and standards of professional behaviour demonstrated during the situation?

63. Information

- What information or intelligence was available?

64. Assessment

- What factors (potential benefits and harms) were assessed?
- What threat and risk assessment methods were used (if any)?
- Was a working strategy developed and was it appropriate?

65. Powers and policy

- Were there any powers, policies and legislation that should have been considered?
- If policy was not followed, was this reasonable and proportionate in the circumstances?

66. Options

- How were feasible options identified and assessed?

67. Action and review

- Were decisions proportionate, legitimate, necessary and ethical?
- Were decisions reasonable in the circumstances facing the decision maker?
- Were decisions communicated effectively?
- Were decisions and the rationale for them recorded as appropriate?
- Were decisions monitored and reassessed where necessary?

- What lessons can be learnt from the outcomes and how the decisions were made?

Questions for supervisors

68. In reviewing and reflecting on decisions, questions that supervisors might ask themselves include:

- Did you recognise and acknowledge instances of initiative or good decisions (and were they passed to managers where appropriate)?
- Did you recognise, question and challenge instances of poor decision making?
- Can you relate the decision making to the Code of Ethics?
- Are there any opportunities for organisational learning?

69. Even where the outcome was not as planned, if the decision was reasonable and proportionate in the circumstances, and made in accordance with the Code of Ethics, the decision maker deserves the support of their supervisor and that of the organisation.

The Joint Decision Model

70. The NDM is the primary decision model for the police service. However, responding to emergencies is a multi-agency activity and the resolution of an emergency will usually involve collaboration between police, fire and rescue, and ambulance services.

71. The Joint Emergency Services Interoperability Programme (JESIP) has been established to improve the ways in which the three emergency services work together at major and complex incidents.

72. When commanders arrive at the scene of a major incident, it is essential that they can quickly establish what is happening around them and jointly agree a plan of action. The Joint Decision Model (JDM) has been adapted from the NDM to enable this to happen.

73. The single difference between the JDM and the NDM is the wording in the central box. The NDM has the Code of Ethics in the centre, whereas the JDM has Working Together, Saving Lives, Reducing Harm.

74. According to JESIP:

75. Joint decisions must be made with reference to the over-arching or primary aim of any response to an emergency: to save lives and reduce harm. This is achieved through a co-ordinated, multi-agency response. Decision makers should have this uppermost in their minds throughout the decision-making process.

76. The mission of policing is to prevent crime and protect the public. The objectives of saving lives and reducing harm are, therefore, entirely consistent with the police mission and the Code of Ethics.

77. In working towards the JESIP objectives, police personnel are expected to act with principles such as integrity, honesty, respect, fairness and selflessness – ie, all the principles and standards of professional behaviour outlined in the Code of Ethics.

78. When involved in joint situations, the three emergency services will apply the model collectively. For example, they will consider and share information, make a shared assessment, and take any respective powers and policies into consideration.

79. Emergency situations may involve differing professional opinions on the best course of action. Reaching a joint decision that is not necessarily the same one as the police would have decided on if they were the only agency making the decision is the nature of collaboration and a feature of joint working. As long as the police representatives can agree the proposed decision is proportionate, lawful, necessary and ethical, there is no conflict with the Code of Ethics.

Appendix C. The 2017 report of the independent review of deaths and serious incidents in police custody by Rt. Hon Dame Elish Angiolini DBW QC

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

.1 The report identified areas which were also identified by the 2009 IPCC report. The 2017 report highlighted common findings of:

- Failure to recognise serious medical conditions due to intoxication (drink or drugs)
- Intoxicated people being in police custody who should be in hospital
- Ambulance service and A&E refusing to assist intoxicated people unless there is also a medical condition
- Insufficient training and awareness by officers of the dangers associated with deterioration in consciousness
- Failure to recognise risk where reduced consciousness may obstruct the airway and the danger of obstruction of the airway by tongue or vomit
- consistent, mandatory training on issues relating to detainee vulnerability is essential
- Comprehensive and standardised mandatory police training is required across forces for custody Sergeants, officers and civilian detention staff on the dangers associated with intoxication
- Training for privatised detention and medical services must be to the same standard as for police staff and include joint training with custody Sergeants and other officers working in the custody environment. Joint training is also required for Forensic Medical Examiners and custody Sergeants

.2 Section 4 of the 2017 report focused upon mental health and police custody and made the following statements:

- At 4.1 “The issue of mental ill health manifests itself time and again within the police custody context. Frequently, police officers find themselves as the first point of emergency contact for those suffering from mental ill health. The first instinct of most members of the public witnessing such an episode is usually to call the police to deal with the individual because of the disturbed or disorderly nature of their behaviour. Even families may call the police rather than an ambulance where they consider their loved one’s behaviour may result in injury or danger and is beyond their ability to cope.”
- At 4.2 “Certain characteristics commonly feature in cases of death involving mental ill health in the police custody context. These include the ability of police officers to recognise and interpret symptoms of mental ill health, rather than attributing disturbed behaviour to drunkenness or drug abuse.”
- At 4.3 “Attempts by officers at de-escalating the conduct by trying to calm and soothe the individual or contain their movement within a reasonable space do not always occur or are often abandoned prematurely with prolonged attempts at physical restraint then ensuing.”
- At 4.4 “These episodes may represent acute medical emergencies – but often they are not treated or understood as such.”
- At 4.5 “Once physically restrained there is often insufficient or no appreciation of the acute medical vulnerability of the detainee and no focus by officers on the need to divert immediately such individuals away from police custody to appropriate emergency health facilities.”
- At 4.8 “Several inquests over many years have highlighted the inadequate police training in or implementation of safe restraint techniques. Similarly, a failure to recognise the behaviour as the manifestation of mental ill health or drug induced mania, and thus a real medical emergency, are all too common in many of the deaths over many years.”
- At 4.10 “The need for consistent national training for the police on dealing with mental ill health is of utmost importance.”
- At 4.11 “Most of these cases involve some use of force and restraint where the focus and determination to physically restrain is at the expense of any awareness

or concern for the dangerousness of the situation and the vulnerability of the detainee to positional asphyxiation and/or sudden death. There have also been many failures in the overall care of vulnerable detainees once detained in crowded, volatile and busy cell areas of a police station."

- At 4.13 "As INQUEST identified in its submission to the Home Affairs Committee (HAC) Inquiry into Policing and Mental Health in May 2014: The fact that nearly half of police-related deaths now involve people with mental illness is evidence that policing on the ground is failing to recognise or adequately adjust to the changing nature of this policing demand"
- At 4.13 "As many of the families have said, their loved ones have not died as a result of 'mental health' but as a direct result of the way in which they were treated, in many cases as a result of the dangerous and excessive use of restraint."
- At 4.14 "Figures published for the last five years consistently show nearly half (46%) of those who died in or following police custody were identified as having mental health concerns."
- At 4.15 "the Metropolitan Police Service established the Independent Commission on Mental Health and Policing, chaired by Lord Victor Adebowale. The report of the Commission was published in May 2013, and set out 28 recommendations. The Home Affairs Committee (HAC) also published a report on policing and mental health in February 2015 with its own recommendations"
- At 4.19 "However, this does not mean that police officers should never take responsibility for dealing with mental ill health. If someone dies in custody then there may have been an urgent need for medical care that was missed."
- At 4.30 "Common to most cases is poor understanding of mental health and all but the most minimal training around mental health issues. This is impacting at all stages in the policing process: from the moment 999 calls are made by members of the public (with decisions around call logging and level of urgency) through to arrest and detention. A full understanding of where things are going wrong is needed to inform the change needed to training. A detailed look at the issues and

learning from recent deaths would provide a valuable source for identifying gaps and problems."

- "Central to the implementation of any change on the ground is the need for more and better training around mental health. Training must be regular enough to ensure sustained learning and to ensure emerging and better practice is incorporated into day to day policing."
- At 4.31 "there have been many reports looking at mental health training. These include the MPS Restraint and Mental Health Review, 2004; the Bradley Report, 2009; ACPO/NPIA Guidance on Responding to People with Mental Ill health or Learning Disabilities; 2010; the Adebowale Report, 2013; the Bradley Commission Report, 2014; Home Affairs Committee on Policing and Mental Health, 2015; the College of Policing draft APP on Mental Health, 2016; and the conclusions of various inquests. These reports have all called for increased and improved training in mental health training within the police service. However, progress has tended to be slow, not sustained, fragmented and with little national coordination."

Appendix D

House of Commons Home Affairs Committee. Policing and mental health. Eleventh Report of Session 2014–15

Ordered by the House of Commons to be printed 3 February 2015.

.1 Section 22 states: “It is relatively common for people with mental health problems who come into contact with the police to also have problems with alcohol or drug use.”

.2 Section 24 states: “The NHS would not turn away a patient with a physical illness just because they were intoxicated. People with mental health problems have exactly the same right to NHS care as everybody else and it is shocking that patients are excluded from health-based places of safety on the basis of informal exclusion criteria. The guidance that people with mental health illness should be treated in a mental health facility needs to be repeatedly reinforced.”

.3 Section 65 states: “We received a lot of support for improved mental health related training for police officers”; and “The main subjects for improved training were general mental health awareness training, de-escalation techniques and the use of restraint”;

.4 Section 67 states: “The police can be trained to recognise some indicators, and the College of Policing current review of mental health training is moving toward an assessment of individual vulnerability rather than trying to identify specific mental ill health, learning disability or condition.”

.5 Section 68 states: “There is a need to improve training for police officers and civilian staff in identifying the signs that someone might be suffering from mental illness. This should be mandatory for all front line officers and include staff in the police control room. This is particularly important for custody Sergeants, who must be adequately equipped with the skills to effectively deal with mental health patients who come into custody suites.”

.6 Section 70 states: “The behaviour of someone having a mental-health crisis can be misunderstood and lead to them being treated in an inappropriate way, for example, their behaviour could be interpreted as dangerous and be met with inappropriate force.”

.7 Section 72 states: “The police are trained to use control and restraint when they find themselves in situations where there is potential for violence. This can include various physical holds, handcuffs or limb restraints” and “Restraint was found to be a cause of death for 16 of the people who died in custody between 1998-99 and 2008-09. (These are all deaths not just those involving someone identified as having mental health illness.) Positional asphyxia was also given as the cause of death in four of the sixteen cases.”

.8 Section 73 states: “In certain situations, the behaviour of someone going through a mental health crisis could be interpreted as potentially violent when they could be delusional and afraid. The police are not always aware that the person they are dealing with is suffering from something that is a medical emergency where restraint is about the worst possible course of action to take. Furthermore, being restrained may intensify that fear and lead them to struggle against the restraint.”

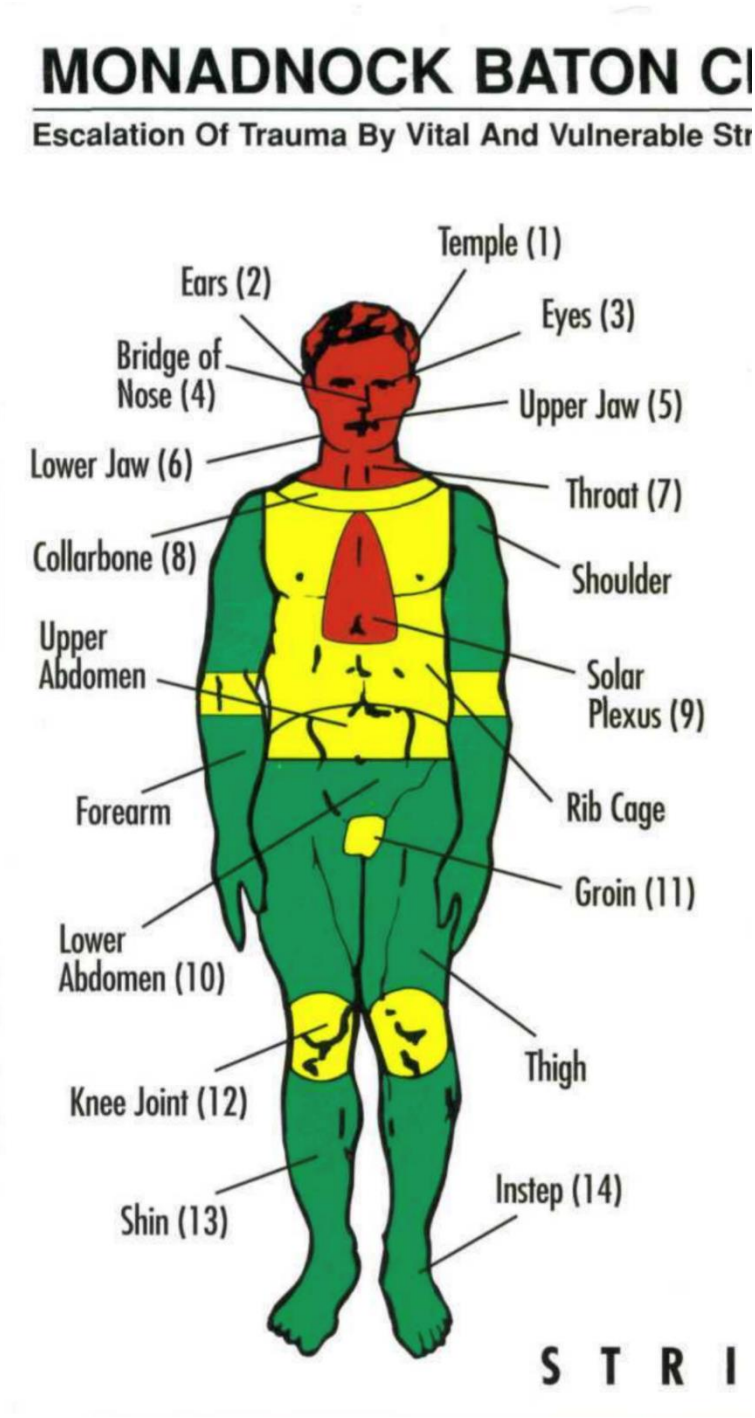
.9 Section 75 states: “Mental health is clearly a large and growing element of modern police work. The current amount of training for new recruits is not enough.” And “There needs to be a national strategy for mental health training for all police. It needs to be updated on a regular basis. As a minimum, it should include awareness of common mental health illnesses, techniques in de-escalation, safe restraint.”

.10 Section 76 states: “Joint training should include de-escalation training, to make sure police officers are familiar with the techniques taught in mental health services.”

.11 Section 77 states: “Restraint should only be used in limited circumstances. Improved training should be given to correctly identify the range of behaviour of someone having a medical emergency rather than automatically presuming that behaviour means they are violent. The training should be aimed at reducing the presumption to use force and restraint on someone who is ill.”

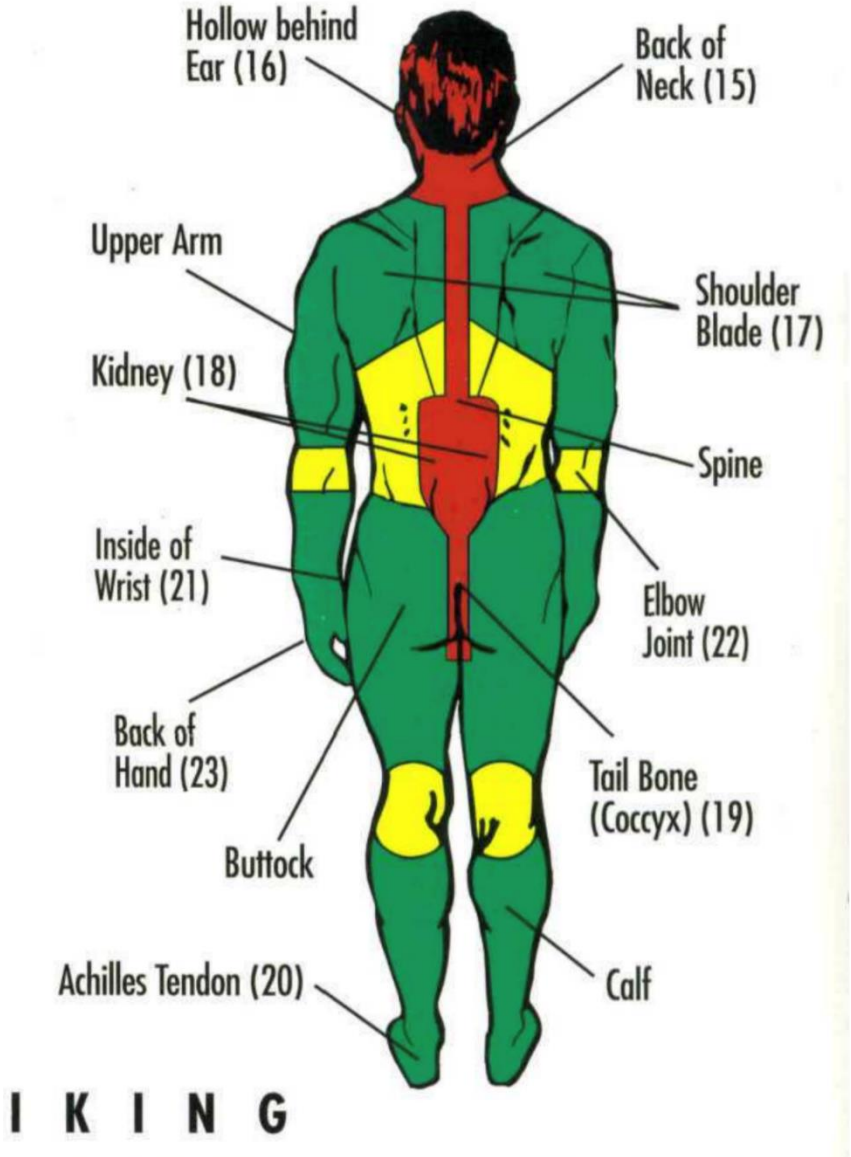
.12 Section 79 states: “The best way to reduce the number of people suffering from mental health issues and who then die in custody is to reduce the number of people with mental health problems entering custody. All that can be done, needs to be done, to ensure that people going through a medical emergency are treated like someone going through a medical emergency. This includes providing sufficient resources to ensure mental health crisis care is available 24 hours a day, seven days a week.”

Appendix E


MONADNOCK BATON CI
Escalation Of Trauma By Vital And Vulnerable Str
Temple (1)
Ears (2)
Eyes (3)
Bridge of Nose (4)
Upper Jaw (5)
Lower Jaw (6)
Throat (7)
Collarbone (8)
Shoulder
Upper Abdomen
Solar Plexus (9)
Forearm
Rib Cage
Groin (11)
Lower Abdomen (10)
Thigh
Knee Joint (12)
Instep (14)
Shin (13)
S T R I

CHART

Striking Areas

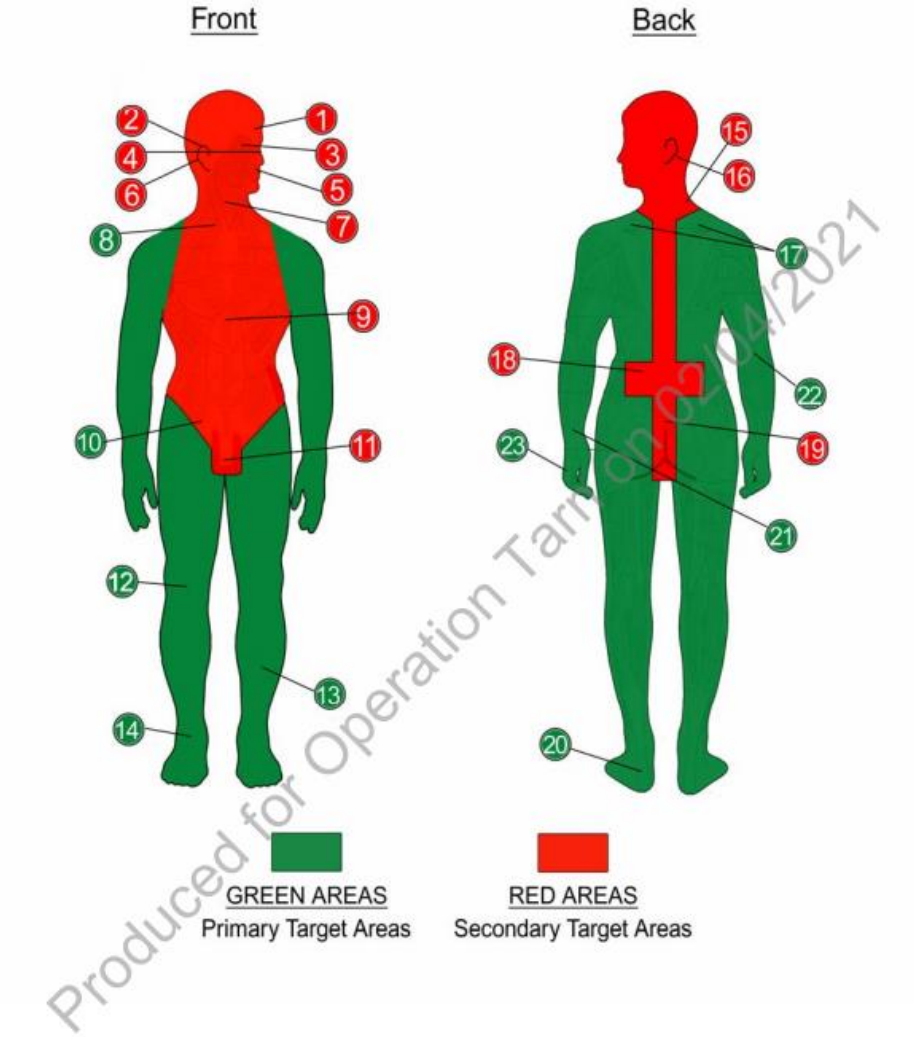


I K I N G

Police Scotland Trauma Chart as of 2015:

NOT PROTECTIVELY MARKED

Escalation of Trauma Chart



Police Scotland Trauma Chart as of 2017:

OPERATIONAL SAFETY TRAINING [redacted] NOT PROTECTIVELY MARKED

FRONT

BACK

GREEN AREAS - PRIMARY TARGET AREAS

RED AREAS - SECONDARY TARGET AREAS

The Head

Blows to the head carry the highest risk of trauma, with possibility of death or serious injury and lasting disability. For this reason, the entire head is a **RED AREA**. It may be struck only when use of deadly force is justified.

The Neck

Connecting the head and body, the neck contains vital structures. It (front and back) is a **RED AREA.** Blows may cause serious injury or death.

Chest

While the chest may be struck with the hand without much danger, the baton concentrates force. A strike could devastate a small area of the chest wall. A forward strike may cut across structures, including the ribs. Potential for serious injury is great. The chest is a **RED AREA.**

Back

The extensive region over the kidneys is a **RED AREA:** not to be struck without justification for use of deadly physical force.

The shoulder blades are **GREEN AREAS;** minimal levels of trauma from a blow would be expected.

Upper Abdomen

The regions bordering the solar plexus are **RED AREAS.**

Damage to abdominal viscera and blood vessels can occur, directly or from ribcage injury. But by far the most vulnerable organ is the spleen.

Version 1.2 (October 2017) 16

Appendix F. Safer Custody - UK and Ireland

.1 The secure custody sector includes:

- the prisons and young offender institutions (YOIs),
- police custody,
- secure transport services,
- court custody,
- immigration,
- child secure accommodation,
- mental health,
- customs custody,
- and military detention.

.2 The UK's three custody areas are England & Wales, Scotland and Northern Ireland.

.3 The three custody areas have their own governance structures, and their own policies and procedures, but they all comply with the European Custody Standards, including:

- The CPT Standards 2015, which are the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment 2015;
- United Nations Mandela Rules (2015);
- United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment (OPCAT);
- UK's National Preventative Mechanism (NPM)

.4 Practices, policies and procedures, along with inspection standards, may be within separate governance structures, but are compliant with each other, and are replicated in many aspects, throughout the different custody areas.

.5 OPCAT was adopted by the UK from 2002, and enforced from 2006. Republic of Ireland is a signatory member of OPCAT. In January 2021 the Office of the Irish Inspector of Prisons published “Plans to allow Ireland to ratify the Optional Protocol to the Convention against Torture (OPCAT) by 2023 form part of the prison Inspectorate’s first-ever strategic plan. The Office of the Inspector of Prisons yesterday published a three-year strategic plan for the period up to and including 2023, which prisons Inspector Patricia Gilheaney said will provide “a strong framework for the continuing development of the Inspectorate, and the vision and strategic ambition to guide our work”. The two key elements of the strategy are the delivery of a comprehensive programme of prison inspections and the State’s pending requirements in respect of ratifying OPCAT.

.6 The NPM is an independent national preventive mechanism to conduct inspections of all places of detention and closed environments. The UK custody sectors also agree to international inspections by the United Nations subcommittee on prevention of torture. This is known as the SPT.

.7 The membership of the SPT is made up of 25 independent people from countries which have acceded to the OPCAT. Those people are drawn from different backgrounds such as medical, legal and custody professions. Members are elected for a 4 years term.

.8 The SPT is currently chaired by the UK

.9 There is also a common framework of paperwork, and terminology, for transferring prisoners between the prison and police estates, and secure transport services.

.10 ‘Safer Custody’ is a generic term used for the holistic custodial process. The common principles involve the assessment of risk to prevent and minimise death and injuries to prisoners, and maintain a human rights approach to the custody process, regardless of which state agency is currently caring for the person.

.11 Her Majesty's Chief Inspector of Prisons for Scotland (HMIPS) is required to inspect the 15 prisons across Scotland in order to establish the treatment of, and the conditions for prisoners and to report publicly on the findings. The Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015 came into force on 31 August 2015 and from this date HM Chief Inspector of Prisons for Scotland assumed overall responsibility for the monitoring of prisons, which is carried out on a day to day basis by independent prison monitors. The United Kingdom is a signatory of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment (OPCAT). Twenty one bodies make up the UKs National Preventative Mechanism (NPM), which has a duty to regularly monitor the treatment of detainees and the conditions in which they are held. In Scotland the Care Inspectorate is a key strategic partner for the prison reviews, whereas in England it is the Care Quality Commission and in Wales the Care Inspectorate (Wales).

.12 The NPM has 21 members who are:

- Her Majesty’s Inspectorate of Prisons for Scotland (HMIPS)
- Her Majesty’s Inspectorate of Prisons (HMIP)
- Her Majesty’s Inspectorate of Constabulary and Fire & Rescue
- Her Majesty’s Inspectorate of Constabulary in Scotland
- Care Inspectorate Scotland
- Care Quality Commission
- Care Inspectorate Wales
- The Children’s Commissioner England
- Criminal Justice Inspectorate Northern Ireland
- Healthcare Inspectorate Wales

- Independent Custody Visiting Association
- Independent Custody Visiting Scotland
- Independent Monitoring Board
- Independent Monitoring Board (Northern Ireland)
- Independent Reviewer Terrorism Legislation
- Lay Observers
- Mental Welfare Commission for Scotland
- Northern Ireland Policing Board Independent Custody Visitor Scheme
- Ofsted (Office for Standards in Education, Children's Services and Skills)
- The Regulation and Quality Improvement Authority
- Scottish Human Rights Commission

.13 Under OPCAT, oversight bodies like the SPT and NPMs focus upon making the practice of prevention a reality. They aim to ensure that the UK custodial functions are using international standards when examining whether they are fulfilling their obligations to protect the human rights of people in detention.

.14 A preventive approach, as defined by the Association for Prevention of Torture, means that visits to places of detention are proactive, rather than reactive, so that signs of ill-treatment are spotted before they occur.

.15 The NHS in England & Wales, and NHS Scotland, are responsible for the delivery of healthcare to prisoners, whether that be within the prison, or receiving the prisoner at NHS services. The NHS assumed responsibility for clinical provision from approximately 2011 in Scotland.

.16 The standard concerning healthcare provision in prison is that prisoners receive the same healthcare and treatment as anyone outside of prison would receive.

.17 Within a custody sector the staff deployed include custody officers who are trained to a minimum UK standard, and healthcare professionals who may be custody Doctors, Nurses or paramedics and comply with the NHS care standards, which are set by the Care Quality Commission (CQC) and Care Inspectorate Wales (CIW), and also link to the UK custody standards.

.18 The National Police Improvement Agency (NPIA) and The Association of Chief Police Officers (ACPO) THE SAFER DETENTION AND HANDLING OF PERSONS IN POLICE CUSTODY (SDHP) 2012 edition states: "This guidance contains information to assist policing in England, Wales and Northern Ireland." And "The NPIA was established by the Police and Justice Act 2006. As part of its remit the NPIA is required to develop policing doctrine, including guidance, in consultation with ACPO, the Home Office and the Police Service. Guidance produced by the NPIA should be used by chief officers to shape police responses to ensure that the general public experience consistent levels of service. The implementation of all guidance will require operational choices to be made at local level in order to achieve the appropriate police response." This 2012 edition replaced the 2006 edition. The 2021 document was decommissioned on 22nd October 2012 and replaced by the online version, with NPIA becoming the College of Policing.

The Police Service, Northern Ireland and 'Safer Custody'

.1. https://www.psni.police.uk/inside-psni/our-departments/district-policing-command/custody-and-healthcare/ states:

- "Reducing Offending and Safer Custody Branch as part of District Policing aims to keep people safe through the delivery of safer detention while also working to reduce vulnerability and offending"
- "There are currently 11 custody suites across Northern Ireland, which are continuously updated and renovated to ensure compliance with safer custody principles and associated codes of practice."

- “The custody function is delivered by team of trained police custody officers; civilian detention officers, healthcare professionals, contract cleaners and other police staff. Additional support for those detrained in police custody is available through initiatives such as; Appropriate Adults, Interpreters, Register Intermediaries and the Northern Ireland Policing Board’s Independent Custody Visitors Scheme.”
- “There are significant challenges facing the delivery and maintenance of safer custody and in particular in addressing the complex needs of vulnerable people and their well-being while in custody. Work is ongoing with Department of Health, Social Services and Public Safety and other criminal justice agencies to explore future custody healthcare provision and secure appropriate referral pathways from custody.”
- “During 2015 there were 26,886 detentions recorded in PSNI custody.”
- “If you have been arrested, we will take you to a custody suite within a police station and you will be treated with fairness, courtesy and respect.”
- “You will be met by custody staff and introduced to the person in charge of the custody suite, known as the Custody Sergeant. The Custody Sergeant is primarily concerned with your welfare in custody and is not involved in the investigation of your case. They will ask the arresting officer questions about your arrest to make sure they are satisfied that your arrest and detention is absolutely necessary.”
- “We understand that being arrested as part of a criminal investigation may be an upsetting experience for you**.** If you feel that this may have an effect on your health and wellbeing, you should tell the Custody Sergeant or the Doctor, who will assist you to make contact with help and advice organisations. They are independent from us and will offer support, assistance and guidance when required.”

.2 https://www.psni.police.uk/know-what-to-do-landing/if-you-have-been-arrested---adult/ “When you are in custody a number of things will happen:

- You will be asked about your physical and mental health so we can look after you properly.
- You will be asked about any alcohol or drugs (prescription or otherwise) you may have consumed prior to your arrest.
- You will be asked if you have any allergies or food intolerances.
- You will be searched for any items which could be used to harm yourself or others.
- Your property may be taken from you for safekeeping. Anything taken from you will be recorded and stored securely until you are released. If we seize any of your property as evidence you will be informed.
- Your clothing may be taken. This may be due to its condition or seized as evidence. If this happens you will be provided with clean clothing and given the opportunity to change with some privacy.
- You will be provided with your rights whilst in custody. You have the right to have someone informed of your arrest, you have the right to consult the codes of practice which we have to follow and you have the right to speak to a solicitor. You can use these rights at any time whilst you are in custody.
- If required, you will be seen by a Doctor to ensure your wellbeing and to assess whether you are fit to be interviewed or detained.

If you have a learning difficulty or other condition, you may be treated as a vulnerable adult. In this case you will be given the assistance of person called an Appropriate Adult"

.3 "You may be required to spend some time in a cell whilst you are detained in custody. The cell will be clean and warm. You will have access to a bed and a toilet. You will be offered three meals a day and provided with a drink if you request one. There may be a camera located in the cell so we can make sure you are safe and well and protect your rights"

.4 https://www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/custody-service-policy-310518-external---policenet-link-removed.pdf states:

- "We ensure that those working in custody are trained and have training refreshed in line with relevant role and responsibilities. We invest in annual refresher training for custody Sergeants and civilian detention officers to reflect best practice and national standards. We will continue to monitor and develop training in line with the changing needs of detained persons in order to deliver safer custody and detention. In addressing particular characteristics of the detained population e.g. disability, gender, nationality, age and religious background the PSNI has developed relevant policy and guidance for custody staff. Supporting services include: translation and interpreter services; Appropriate Adults Scheme; Medical practitioner reviews; and registered intermediaries."
- "There are significant oversight bodies and pieces of legislation that set out the 'rules' of police custody, most notably: • The Police and Criminal Evidence (NI) Act 1989 (PACE), supplemented by Codes of Practice; • Practitioner guidance issued by the College of Policing referred to as Authorised Professional Practice (APP). College of Policing Authorised Professional Practice 'Custody & Detention); • Optional Protocol to the Convention Against Torture (OPCAT); • The Terrorism Act 2000 (TACT Independent reviewer); • The Police Ombudsman for Northern Ireland (PONI); • The Criminal Justice Inspectorate Northern Ireland (CJINI-RQIA); • Her Majesty's Inspectorate of Constabulary (HMIC); • The Information Commissioner (ICO); and • The Data Protection Act 2018."
- "We provide custody provision throughout Northern Ireland. There are 9 fully operational suites: Strand Road; Coleraine; Antrim; Musgrave; Banbridge; Lurgan; Dungannon; Omagh and Enniskillen. There are 2 contingency suites, Strabane and Bangor, which can be opened by exception, to provide additional cell capacity if required. Musgrave and Antrim Custody suites are designated under the Terrorism Act (2000) as Serious Crime Suites. The PSNI custody estate reflects Home Office best practice where possible e.g. including observation cells, life signs monitoring, and ability to segregate and separate children and adults within a custody suite."

- “We strive to use technology to enable the custody process to be streamlined, efficient, effective and safe. All custody systems are auditable and operate in line with the PSNI policy on Data Protection and Information Security. Custody Information is available 24/7 on Police net for advice and guidance. The site is maintained and updated by District Policing Command and reflects best practice.”

Appendix G: Independent Advisory Panel on Deaths in Custody

Common principles for safer restraint

General

a. Physical restraint is the lawful use of force using approved physical touching and holding techniques which results in the restriction of movement of one person by another.

b. Staff working in custodial establishments or dealing with members of the public have a primary responsibility to safeguard all those with whom they have professional contact.

c. Staff must work to establish and foster a culture of non-violence where possible.

d. The use of any form of restraint must be the last resort and must be limited to those situations where de-escalation and other non-physical diversion techniques have failed to resolve the situation.

e. Every episode of restraint must be necessary, justifiable and proportionate to the perceived threat

f. Whenever physical restraint is used it can have significant psychological and emotional effects upon everyone involved, everyone who witnesses the events and also upon the wider establishment.

g. Physical restraint can occasionally result in the death of the individual being

restrained.

Training

h. Only techniques that have been approved and taught may be used to apply physical restraint.

i. Only trained and authorised staff may apply restraint.

j. Staff must understand the non-physical and the physical techniques that they will use.

k. They must have been trained in the safe application of those techniques.

l. Their skills in both de-escalation and all of the approved techniques must be maintained through regular training.

Management

m. If three or more staff are actively involved in a restraint then one of those staff must be in control of the restraint (Controller) and it must be clear at all times, to all those involved in the restraint who the Controller is.

n. At the start of an episode of restraint the staff member responsible for protecting the detainee's head, neck and breathing will assume the role of Controller regardless of rank.

o. The Controller will be confirming their role to colleagues as soon as possible after the start of the restraint using a designated phrase. (e.g. "I now have control of this incident")

p. If a suitably trained member of staff not involved in the actual restraint process is present they should become the Controller of the restraint as soon as practical.

q. Control of the restraint will pass between Controllers only when offered and positively accepted using designated phrases. (eg “I now have control of this incident” / “You have control”)

r. During a period of restraint the techniques being applied must be frequently reviewed with the aim to safely remove all forms of physical restraint in the shortest time practical.

s. The Controller must have the authority to order the alteration or release of any of the restraint hold(s).

Medical

t. In some environments the specific health risks of detainees may be known, in other environments they will not be known. All approved restraint techniques must take into account the possibility that underlying disease(s) may render an individual more susceptible to adverse effects and possibly death.

u. The vital signs (Airways, Breathing, Circulation) of the restrained individual must be assessed as soon as possible after the commencement of restraint by a member of the team nominated to do so by the Controller.

v. These assessments of vital signs must be repeated frequently throughout the period

of restraint and the results made known to the Controller. Medical advice must be obtained if any concerns are expressed.

w. If the restraint is a planned intervention in an institution with trained healthcare staff then they must be present throughout the period of restraint.

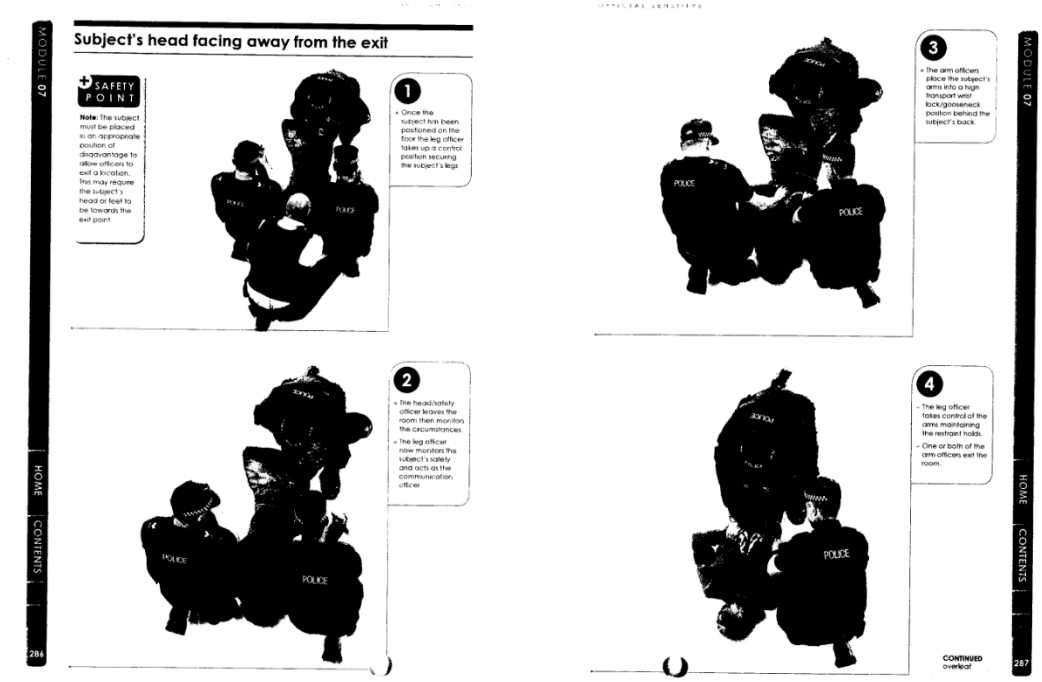
Governance

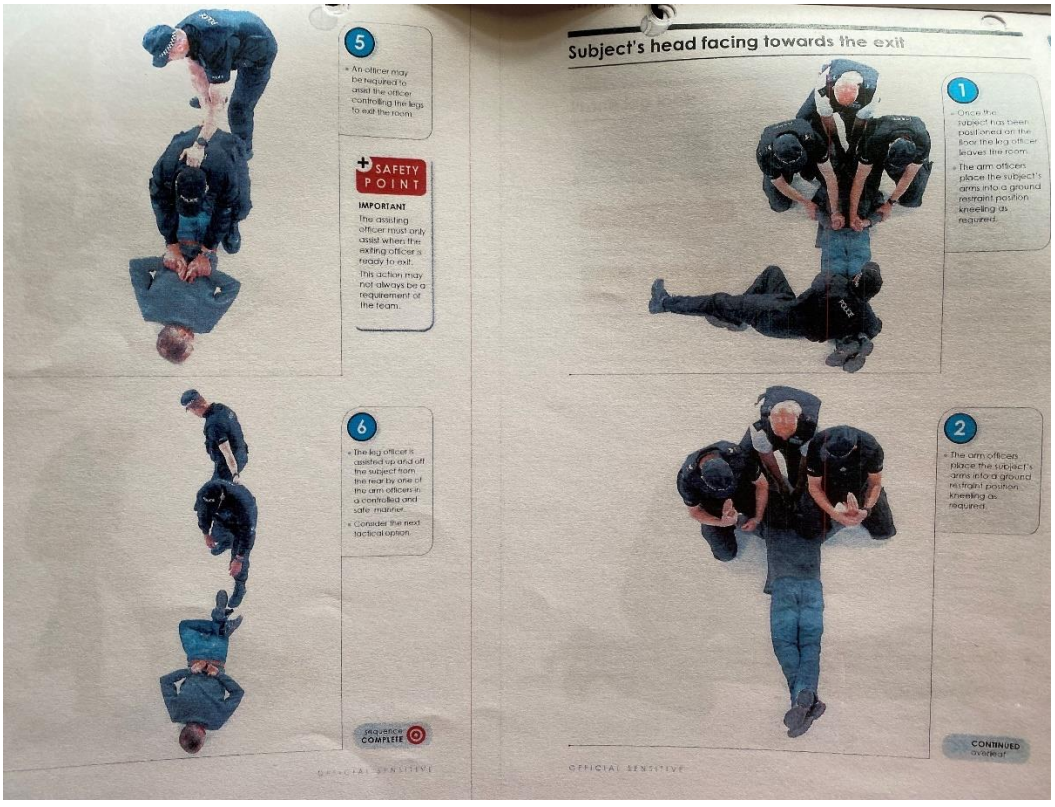
x. All episodes of restraint should be video recorded if at all possible.

y. Detailed and accurate records of all incidents of restraint must be maintained and analysed locally and centrally. These data should be used to review techniques and practices and to inform staff appraisals, training and development.

z. Debriefing procedures must be established and followed for all those involved (including if possible the detainee). If three or more officers are involved in any single episode of restraint there must be a formal face to face debriefing procedure by a trained member of staff.

Appendix H. Cell Extraction/relocation Techniques





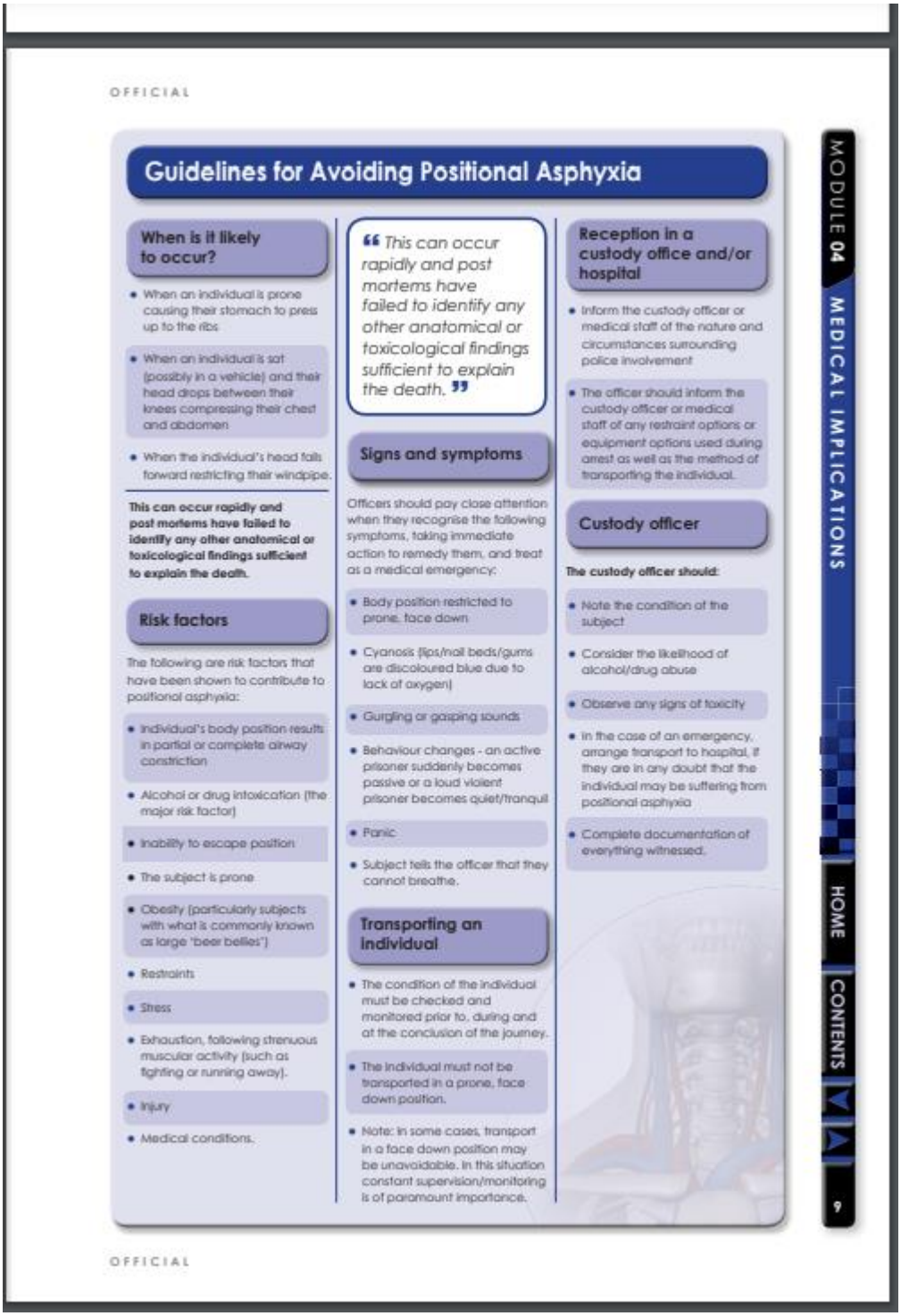
Appendix I: The Vulnerability Assessment Framework

- "The VAF (Vulnerability Assessment Framework) is a simple tool to prompt identifying vulnerability in all circumstances where the police have contact with victims, suspects and witnesses. It enables officers to build a more detailed record of the circumstances and information that led them to identify someone as vulnerable and in need of assistance, arrest or referral. The ABCDE system is as follows:

- **Appearance and atmosphere:** what you see first, including physical problems such as bleeding.
- **Behaviour:** what individuals are doing, and if this is appropriate behaviour given the situation.
- **Communication:** what individuals say and how they say it.
- **Danger:** whether individuals are in danger and whether their actions put other people in danger.
- **Environment:** where they are situated, whether anyone else is there and what impact the wider circumstances may have on the individual's health and safety

- "Information concerning the individual's vulnerability at the point of arrest or detention under section 136 MHA 1983 may prove valuable for medical diagnoses and risk management. Where possible, officers should convey this information to ambulance staff, healthcare professionals and/or police custody staff without delay."
- "Behaviour which may raise concern about people's risk of harm to themselves or to others includes attempting or threatening suicide (eg, expressing ideas, intentions or plans relating to suicide)."
- "When considering whether it is necessary and appropriate to detain a person using section 136 MHA 1983, police officers should use the National Decision Model to guide their approach."

Appendix J: Guidelines to prevent Positional Asphyxia



OFFICIAL

Guidelines for Avoiding Positional Asphyxia

When is it likely to occur?

- When an individual is prone causing their stomach to press up to the ribs
- When an individual is sat (possibly in a vehicle) and their head drops between their knees compressing their chest and abdomen
- When the individual's head falls forward restricting their windpipe.

This can occur rapidly and post mortems have failed to identify any other anatomical or toxicological findings sufficient to explain the death.

Risk factors

The following are risk factors that have been shown to contribute to positional asphyxia:

- Individual's body position results in partial or complete airway constriction
- Alcohol or drug intoxication (the major risk factor)
- Inability to escape position
- The subject is prone
- Obesity (particularly subjects with what is commonly known as large "beer bellies")
- Restraints
- Stress
- Exhaustion, following strenuous muscular activity (such as fighting or running away).
- Injury
- Medical conditions.

"This can occur rapidly and post mortems have failed to identify any other anatomical or toxicological findings sufficient to explain the death."

Signs and symptoms

Officers should pay close attention when they recognise the following symptoms, taking immediate action to remedy them, and treat as a medical emergency:

- Body position restricted to prone, face down
- Cyanosis (lips/nail beds/gums are discoloured blue due to lack of oxygen)
- Gurgling or gasping sounds
- Behaviour changes - an active prisoner suddenly becomes passive or a loud violent prisoner becomes quiet/tranquil
- Panic
- Subject tells the officer that they cannot breathe.

Transporting an individual

- The condition of the individual must be checked and monitored prior to, during and at the conclusion of the journey.
- The individual must not be transported in a prone, face down position.
- Note: In some cases, transport in a face down position may be unavoidable. In this situation constant supervision/monitoring is of paramount importance.

Reception in a custody office and/or hospital

- Inform the custody officer or medical staff of the nature and circumstances surrounding police involvement
- The officer should inform the custody officer or medical staff of any restraint options or equipment options used during arrest as well as the method of transporting the individual.

Custody officer

The custody officer should:

- Note the condition of the subject
- Consider the likelihood of alcohol/drug abuse
- Observe any signs of toxicity
- In the case of an emergency, arrange transport to hospital, if they are in any doubt that the individual may be suffering from positional asphyxia
- Complete documentation of everything witnessed.

MODULE 04 MEDICAL IMPLICATIONS HOME CONTENTS 9

OFFICIAL

Appendix K: Medical Implications for Restraint

Restraint

Restraint can thus cause problems with breathing: the shoulders may be held, the belly pressed (someone sits on it/ kneels on it, or the subject lies flat) and the airway may become narrowed (the head forced or flopped right forward can cause this, but so too can having the head flopped back or pressing on the neck).

There are always risks; lying face down can compress the belly, but lying flat on the back risks inhaling vomit if they throw up.

All of these can prevent oxygen getting into the body, or carbon dioxide getting out.

Especially vulnerable are those: (i) already having to breathe hard to get oxygen in and carbon dioxide out due to severe exertion (ii) with a medical condition causing low oxygen levels already (e.g. pneumonia) or acid blood (for instance, some cases of kidney failure or high blood sugar due to diabetes).

Restraint may thus cause even lower oxygen levels (or higher carbon dioxide levels): the patient gets more and more agitated, and needs more and more restraint. In the end, the carbon dioxide levels rise so high (and/or oxygen levels so low) that the patient becomes quieter and struggles less.

This can be a point very close to death.

What is positional asphyxia?

In simple terms an individual can stop breathing because of the position they have been held in. Positional asphyxia is likely to occur when a subject is in a position that interferes with inhalation and/or exhalation and cannot escape from that position.

Appendix L: Medical Implications for Head Injuries

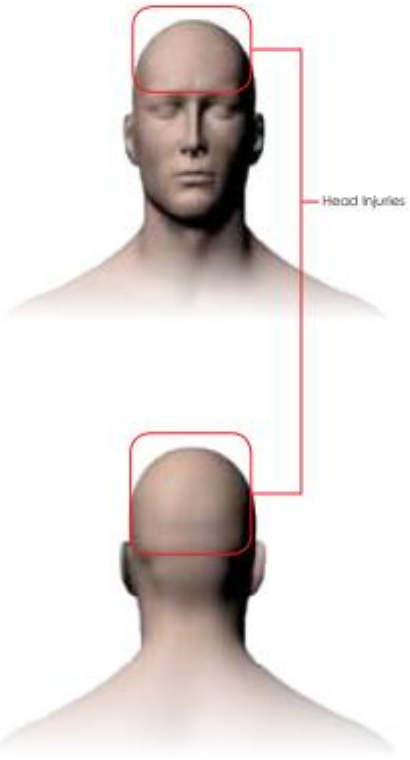
Head Injuries

Many of the techniques used may result in trauma to the head. This may result from direct blows to the head from body weapons or the use of Personal Protective Equipment (PPE). Further, head injury may result from striking the head on a hard surface during an uncontrolled fall. The resulting injuries may be classified as follows:

Diffuse Injury – Concussion and Diffuse Axonal Injury (DAI)

The brain is soft in consistency and is loosely anchored within the bony box of the skull. A blow to the head may cause acceleration/deceleration of the soft brain inside the bony skull box resulting in bruising (contusion) or, more seriously, stretching or tearing of nerve tracts within the brain causing diffuse axonal injury (DAI). The outcome is an alteration in conscious level or complete loss of consciousness.

An alteration in conscious level, including complete loss of consciousness is the hallmark of significant brain injury and warrants urgent medical attention.



Focal Impact Injury

Typically occurs when the head strikes a protruding object or following a blow using PPE.

There may be a laceration to the scalp with possibility of underlying skull fracture. There may be significant bleeding from torn blood vessels in the scalp and an alteration in conscious level. These injuries are associated with a high risk of epilepsy and brain infection. Urgent medical attention is necessary.

Bleeding around or within the brain

This may or may not be associated with skull fracture. In a fit, healthy subject significant force is required. However in subjects with a history of chronic substance abuse bleeding may occur with minimal force.

Again the cardinal feature is an alteration in conscious level, which may be transient but then recur (this is called the lucid interval).

Look also for any reduction in the use of arms or legs or variation in the size of the pupils. Particular care must be exercised in subjects who have been drinking or where substance abuse is suspected.

Do not assume a change in conscious level is due to alcohol or drugs. The slightest suspicion of injury demands urgent medical attention.

Appendix M: Police Scotland Incident Grading Codes

Each incident is THRIVE assessed - the process is explained in the above link - it means that we might deal with the same type of call differently depending on the needs of the caller after assessing their vulnerability and the risk and harm posed to them.

CODE	DESCRIPTION
AA-92	PERSONAL ATTACK ALARM
AA-94	AUDIBLE ONLY
AA-95	POLICE INSTALLATION
AA-96	LONE WORKER
AA-97	CCTV
AD-01	EXTERNAL FORCE REQUEST
AD-02	LOSS OF 999 SERVICE
AD-03	VIP VISIT

CODE	DESCRIPTION
AD-04	EXERCISE
AD-05	TASK INCIDENT
AD-06	INTERNAL FORCE REQUEST
AD-07	ERROR
AD-08	LOST/FOUND PROPERTY
AD-09	POLICE INFORMATION
AD-10	SPECIAL EVENTS/OPERATIONS
AD-11	FALSE CALL
AD-19	DUPLICATE INCIDENT
AD-21	POLICE EMERGENCY
AD-22	POLICE GENERATED ACTIVITY
AD-23	ASSIST MEMBER OF THE PUBLIC
AD-31	MESSAGE FOR DELIVERY
AD-32	BAIL/CURFEW/ADDRESS CHECKS
AD-52	STANDING COMPLAINT
AD-74	LICENSING
AD-75	DOMESTIC BAIL CHECK
AD-80	EXTERNAL AGENCY REQUEST
AD-99	TEST INCIDENT
AD-MI	MAJOR INCIDENT
CTI	CTI
AB-24	PUBLIC NUISANCE
AB-27	DRUGS/SUBSTANCE MISUSE
AB-28	DISTURBANCE
AB-46	ABANDONED VEHICLES

AB-53	NOISE
AB-55	DRINKING IN PUBLIC
AB-56	NEIGHBOUR DISPUTE
AB-57	COMMUNICATIONS
AB-58	HATE CRIME
AB-59	ASBO
CR-60	WILDLIFE CRIME
CR-61	ABDUCTION/EXTORTION/SEXTORTION
CR-62	SEXUAL OFFENCE
CR-63	ROBBERY

CODE	DESCRIPTION
AA-91	INTRUDER
CR-64	THEFT
CR-65	VEHICLE CRIME
CR-66	BOGUS CALLER
CR-67	HOUSEBREAKING
CR-68	CRIME IN PROGRESS
CR-69	SUSPECT PERSONS
CR-71	ASSAULT
CR-78	DAMAGE
CR-79	OTHER CRIME
PS-29	PUBLIC DEMO
PS-30	ESCAPEE/AWOL
PS-33	INDUSTRIAL DISPUTE
PS-34	FIREARMS INCIDENT
PS-35	BOMB THREAT
PS-36	SUSPICIOUS INCIDENT
PS-81	FIRES
PS-82	EXPLOSION
PS-83	UTILITIES INCIDENT
PS-84	CHEMICAL SPILLAGE
PS-85	ANIMALS
PS-86	WEATHER
PS-87	WATERBORNE INCIDENT
PS-88	EXPLOSIVES FOUND
PS-89	CBRN
PW-25	MISSING PERSON/ABSCONDER
PW-26	SUDDEN DEATH
PW-38	UNAUTHORISED ENCAMPMENT

PS-81	FIRES
PS-82	EXPLOSION
PS-83	UTILITIES INCIDENT
PS-84	CHEMICAL SPILLAGE
PS-85	ANIMALS
PS-86	WEATHER
PS-87	WATERBORNE INCIDENT
PS-88	EXPLOSIVES FOUND
PS-89	CBRN
PW-25	MISSING PERSON/ABSCONDER
PW-26	SUDDEN DEATH
PW-38	UNAUTHORISED ENCAMPMENT
PW-40	DOMESTIC INCIDENT
PW-51	ACCIDENTS
PW-70	ABANDONED/SILENT 999 CALL
PW-72	CONCERN FOR PERSON
PW-73	INSECURE PREMISES
PW-76	CHILD PROTECTION
PW-77	IMMIGRATION

CODE	DESCRIPTION
PW-90	SEARCH AND RESCUE
TR-41	ROAD TRAFFIC COLLISION
TR-43	ROAD TRAFFIC MATTER
TR-44	VEHICLE PURSUIT
TR-45	RAIL INCIDENT
TR-47	MARITIME INCIDENT
TR-48	AIRPORT GROUND INCIDENT
TR-49	AIRPORT FULL EMERGENCY
TR-54	ROAD TRAFFIC OFFENCE
TR-50	AVIATION INCIDENT
AA-98	VEH TRACK AND RECOVERY
AA-99	VEHICLE AUDIBLE ALARMS
TR-15	DRONE/UAS/UAV INCIDENT
PS-37	PLANNED SHOOT / PEST CONTROL
AD-20	FORENSIC EXAMINATION
CR-16	FRAUD INCIDENT
AD-12	SCHENGEN INCIDENT
PW-17	HUMAN TRAFFICKING

Appendix N: Expert's Background

BTEC

Edexcel BTEC Level 3 Award

in THE DELIVERY OF CONFLICT MANAGEMENT TRAINING (QCF)

is awarded to

JOANNE CAFFREY

who has completed an approved programme at

NFPS LTD

AWARDED : DECEMBER 2012

THIS DOCUMENT CONSISTS OF MORE THAN ONE PAGE

[redacted]

NFPS Ltd

[redacted]

Lesley Davies
Responsible Officer
Pearson Education Ltd.

Ofqual

Llywodraeth Cymru
Welsh Government

cea
Rewarding Learning

PH501140797 045

ALWAYS LEARNING

PEARSON

BTEC

Pearson
BTEC Level 3
Advanced Award

in SAFE AND EFFECTIVE USE OF THE EMERGENCY RESPONSE BELT

is awarded to

JOANNE CAFFREY

who has completed an approved programme at

NFPS LTD

AWARDED : OCTOBER 2014

THIS DOCUMENT CONSISTS OF MORE THAN ONE PAGE

[redacted]

NFPS Ltd

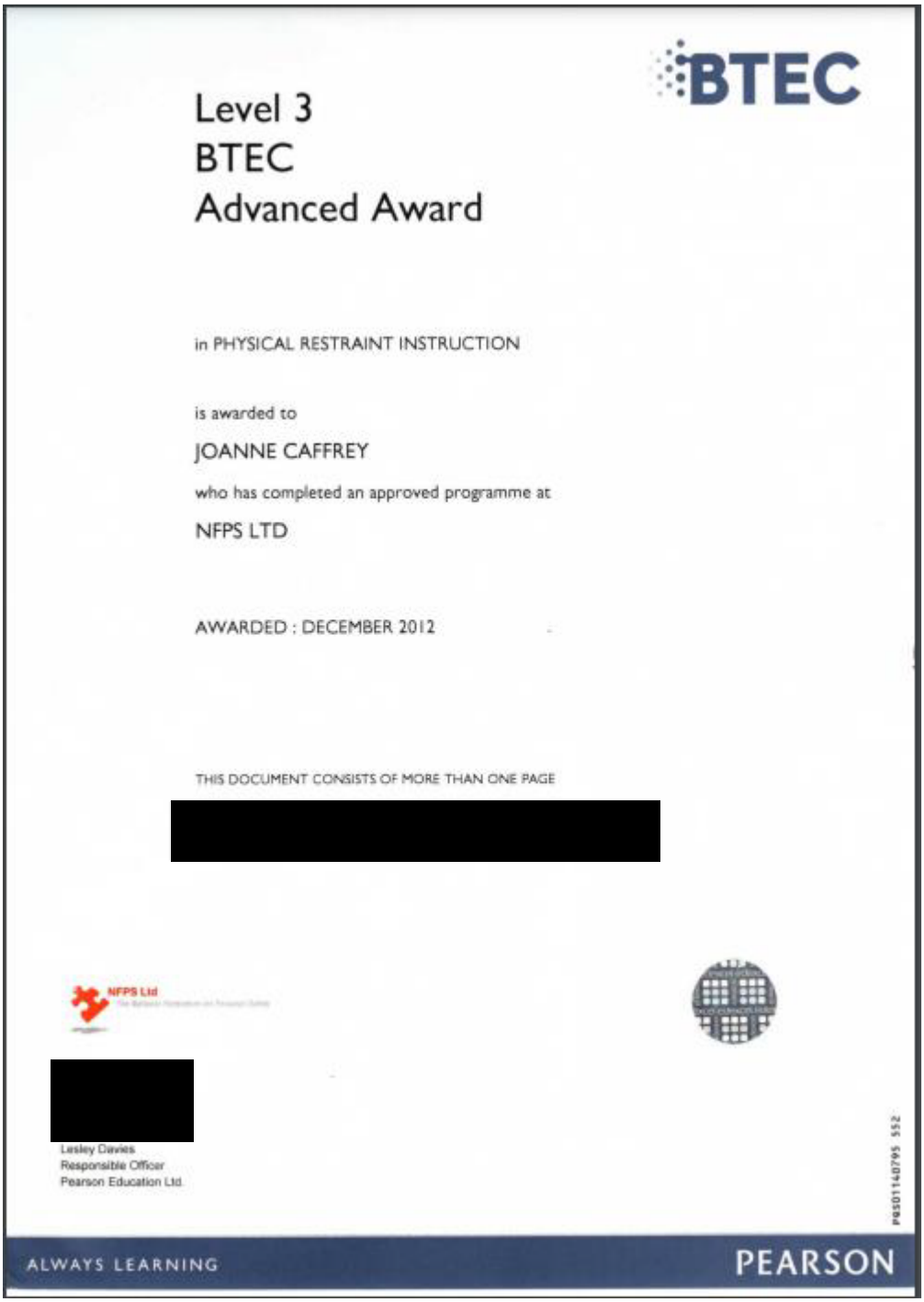
[redacted]

Lesley Davies
Responsible Officer
Pearson Education Ltd

PB514 04266840 885

ALWAYS LEARNING

PEARSON



BTEC

Level 3
BTEC
Advanced Award

in PHYSICAL RESTRAINT INSTRUCTION

is awarded to

JOANNE CAFFREY

who has completed an approved programme at

NFPS LTD

AWARDED : DECEMBER 2012

THIS DOCUMENT CONSISTS OF MORE THAN ONE PAGE

[redacted]

NFPS Ltd

[redacted]

Lesley Davies
Responsible Officer
Pearson Education Ltd

PGS01140795 552

ALWAYS LEARNING PEARSON

BTEC

Pearson
BTEC Level 3
Advanced Award

in SAFE AND EFFECTIVE USE OF RESTRAINT EQUIPMENT

is awarded to

JOANNE CAFFREY

who has completed an approved programme at

NFPS LTD

AWARDED : OCTOBER 2014

THIS DOCUMENT CONSISTS OF MORE THAN ONE PAGE

[redacted]

NFPS Ltd

[redacted]

Lesley Davies
Responsible Officer
Pearson Education Ltd.

P0114 04266839 860

ALWAYS LEARNING

PEARSON

BTEC

Level 3
BTEC
Advanced Award

in SELF-DEFENCE INSTRUCTION

is awarded to

JOANNE CAFFREY

who has completed an approved programme at

NFPS LTD

AWARDED : DECEMBER 2012

THIS DOCUMENT CONSISTS OF MORE THAN ONE PAGE

[redacted]

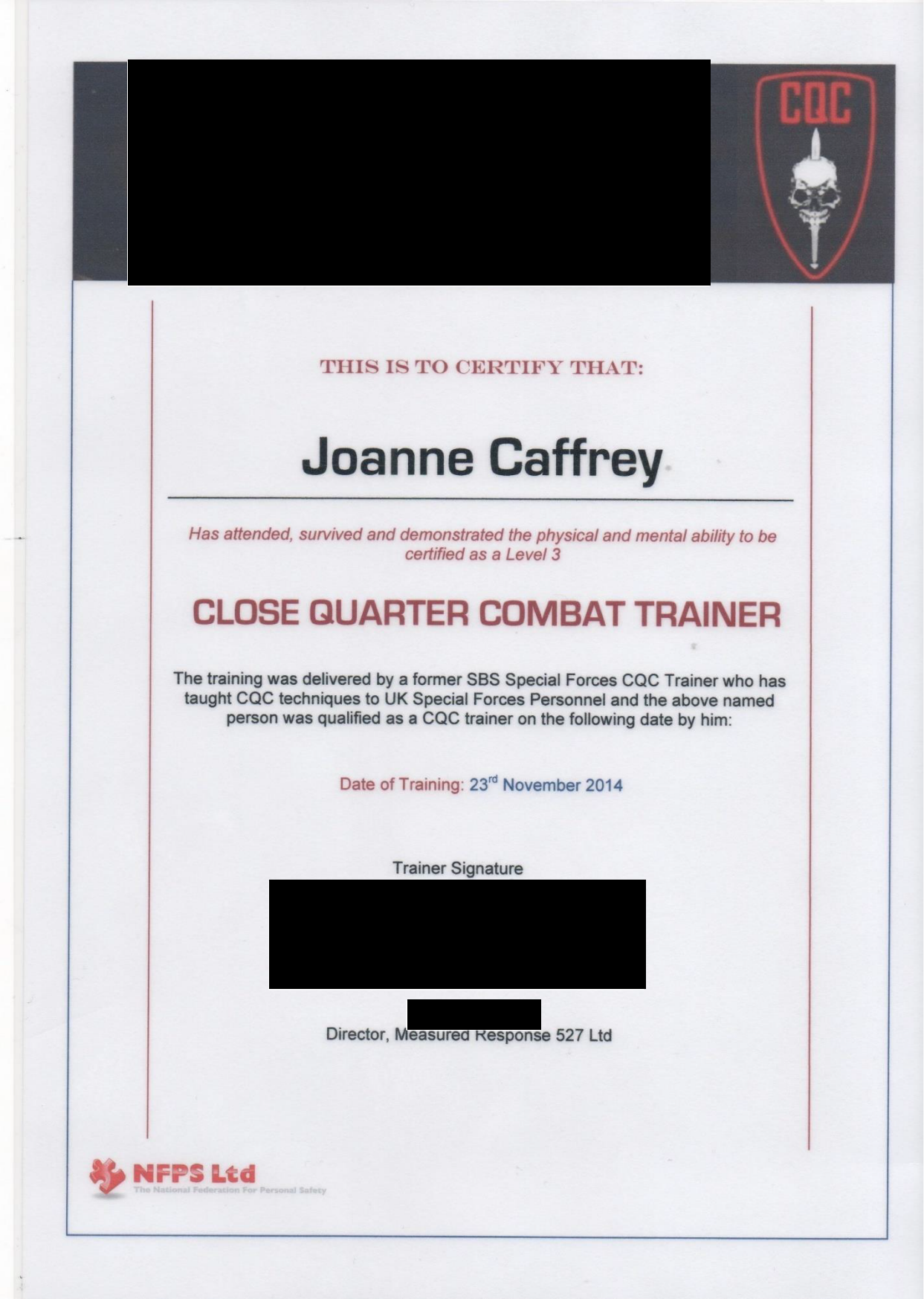
NFPS Ltd

[redacted]

Lesley Davies
Responsible Officer
Pearson Education Ltd.

ALWAYS LEARNING

PEARSON



[redacted]

CQC

THIS IS TO CERTIFY THAT:

Joanne Caffrey

Has attended, survived and demonstrated the physical and mental ability to be certified as a Level 3

CLOSE QUARTER COMBAT TRAINER

The training was delivered by a former SBS Special Forces CQC Trainer who has taught CQC techniques to UK Special Forces Personnel and the above named person was qualified as a CQC trainer on the following date by him:

Date of Training: 23rd November 2014

Trainer Signature

[redacted]

[redacted]

Director, Measured Response 527 Ltd

NFPS Ltd
The National Federation For Personal Safety

My experience as an expert witness includes advising upon, approximately, 200 cases. These cases are distributed between England, Wales, Scotland, Northern Ireland, Republic of Ireland and the Isle of Man.

The cases involve custody sectors of police, prison, mental health, immigration, security staff and the children's sector. (Custody commences from the point of initial contact & arrest)

I have provided my services for coroner, fatal accident inquiries, civil, criminal and misconduct cases. I have been engaged by coroners and legal teams representing the defence and prosecution/claimant.

I have repeat business from the Police Federation, Police Ombudsman agencies and the Crown Office.

My main areas of service concern:

- Death during restraints
- Serious injury during restraints
- Ligature deaths

I am registered with, and vetted by, the National Crime Agency (NCA) for custody topics.

I have currently been engaged for 12 ligature deaths in custody and several deaths during restraints

1 I was a police officer for nearly 24 years, 17 of these as a Sergeant. I specialised in the Safer Handling of Detained Persons / Safer Custody, and the use of force. I served 7 years as a custody Sergeant dealing with male and female detainees, police detainees under PACE and convicted prisoners under Prison Rules and prison PSIs and PSOs during Operation Container, and trained police officers in prison rules.

Not only did I complete 7 years of front-line police custody duties for use of force and safer custody, but I progressed to 10 years of emergency planning, safer custody and use of force (principles and practices theory) training delivery and consultancy, assessment of staff, risk assessing custody environments, and major incident management of prisoners between prisons and police custody. I was force planning lead for Operation Container for the housing of prisoners from prison within the police estate, and trained to Tactical Support Group (TSG) standards (prison service 'Tornado' equivalent). I performed front line duties as part of a tactical support group in the use of shields and fire insemination.

I taught police officers about Prison Rules, PSIs and PSOs and worked on Operation Container as both a custody officer and a force supervisor and trainer.

My safer custody experience covers from point of stop and search/arrest in the public domain, through to police custody, court custody, prison custody and all the transportation between by private contractors.

Safer Custody is a national holistic strategy for providing a common framework of understanding and governance concerning any detained person within the Criminal Justice System, regardless of which agent is currently caring for the person. From point of stop and search/arrest, through police, court and prison custody, and all associated private contractors providing transport services between the agencies.

Safer Custody topics include:

- Use of force and use of restraints
- Custody staff and training requirements
- Custody paperwork
- Risk assessments of detainees
- Risk assessments of cells, buildings and activities
- Information sources e.g. PNC, PER
- Transportation & fleet management
- Management and supervision of detainees – visits, rousing, cell searches
- Equality and person centred care
- Healthcare and medication requirements
- Safe storage and management of medication
- Clinical/ medical settings and staff within custody
- Cell occupancy and cell risk sharing assessments
- Hygiene – bedding, toilets, clothing and cleaning
- Out of cells – showers, socialisation, exercise, interviews
- Food safety – choking assessments and food safety
- Dependencies – alcohol, drugs
- Mental ill health – assessments, medical needs, adaptations, use of force risks, acute behaviour disturbance, excited delirium, schizophrenia, depression etc
- Managing head injuries
- Positional asphyxia
- Infections and communicable diseases
- Technology – CCTV, audio recording
- Multi-disciplinary safeguarding processes
- Custody contingency planning
- Sector specific national guidance – prison Service PSIs & PSOs, Police PACE & Codes of Practice.

The secure custody sector includes:

- the prisons and young offender institutions (YOIs),
- police custody,
- secure transport services,
- court custody,
- immigration,
- child secure accommodation,
- mental health,
- customs custody,
- and military detention.

The UK's three custody areas are England & Wales, Scotland and Northern Ireland.

The three custody areas have their own governance structures, and their own policies and procedures, but they all comply with the European Custody Standards, including:

- The CPT Standards 2015, which are the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment 2015;
- United Nations Mandela Rules (2015);
- United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment (OPCAT);
- UK's National Preventative Mechanism (NPM)

Practices, policies and procedures, along with inspection standards, may be within separate governance structures, but are compliant with each other, and are replicated in many aspects, throughout the different custody areas.

OPCAT was adopted by the UK from 2002, and enforced from 2006. The NPM is an independent national preventive mechanism to conduct inspections of all places of detention and closed environments, and has 21 organisations as members. The UK custody sectors also agree to international inspections by the United Nations

subcommittee on prevention of torture. This is known as the SPT. The membership of the SPT is made up of 25 independent people from countries which have acceded to the OPCAT.

I am familiar with the assessment paperwork of the NPM membership. The NPM membership includes:

- Her Majesty's Inspectorate of Prisons for Scotland (HMIPS)
- Her Majesty's Inspectorate of Prisons (HMP)
- Her Majesty's Inspectorate of Constabulary and Fire & Rescue
- Her Majesty's Inspectorate of Constabulary in Scotland
- Care Inspectorate
- Care Quality Commission
- Care Inspectorate Wales
- The Children's Commissioner England
- Criminal Justice Inspectorate Northern Ireland
- Healthcare Inspectorate Wales
- Independent Custody Visiting Association
- Independent Custody Visiting Scotland
- Independent Monitoring Board
- Independent Monitoring Board (Northern Ireland)
- Independent Reviewer Terrorism Legislation

- Lay Observers
- Mental Welfare Commission for Scotland
- Northern Ireland Policing Board independent Custody Visitor Scheme
- Ofsted (Office for Standards in Education, Children's services and Skills)
- The Regulation and Quality Improvement Authority
- Scottish Human Rights Commission

I achieved national awards for my custody training programmes and associated work in this area which included the 2012 British Association of Women in Policing, Excellence in Performance, Award.

I received internal awards such as Assistant Chief Constable and Deputy Chief Constable awards.

During my police service I also trained as an intoxilyser trainer, completing the train the trainer course at National Police Training, Harrogate. During my service, as a custody Sergeant, I conducted many evidential breath tests, and trained others to conduct them. I am familiar with the MGDD process. I have experience of providing expert witness reports concerning the evidential breath test procedure and hospital blood procedures. During my time as a custody Sergeant it was the Sergeant's responsibility to conduct all breathalyser and blood procedures. This changed to allow constables to conduct the procedures following the introduction of 'safer custody' when the Sergeant was removed from the investigative process.

Since leaving the Police in 2013 I established my own training company focusing on safeguarding during challenging behavior and physical intervention. I am able to deliver training and consultancy on a range of topics concerning the management of challenging behaviour, and safer custody. These topics include:

- Conflict management, breakaway, self-defence, close quarter combat, physical intervention, physical restraint
- Risk assessment, health & safety, manual handling
- Use of restraint equipment e.g. handcuffs, soft cuffs, restraint belts
- Safeguarding & child protection
- Complex medical and behaviour needs
- BTEC 3 days disengagement and physical intervention training for clinical settings, for use on vulnerable adults and children
- level 2 SIA module
- Level 2 conflict management
- level 2 handcuffing & soft restraints
- level 2 breakaway and self defence
- level 2 education sector challenging behaviour
- level 2 elderly services challenging behaviour
- Managing challenging behaviour – OCN Credit 4 learning
- Managing the use of force – OCN Credit 4 learning
- Managing Safeguarding – OCN Credit 4 Learning & CPD
- Managing Medication – OCN Credit 4 learning & CPD
- Tactical Communications & Mediation – OCN Credit 4 Learning & CPD
- Mental Health Fist Aid – OCN Credit 4 learning & CPD
- Stop, search & confiscate – OCN Credit 4 learning
- Managing safer custody – OCN Credit 4 learning
- Managing Suicide & Self-Harm – OCN Credit 4 learning
- Managing Deprivation of Liberty – OCN Credit 4 learning & CPD
- Restraint Specific First Aid – OCN Credit 4 learning
- Managing Head Injuries – OCN Credit 4 Learning
- Managing Sensory Integration – OCN Credit 4 learning
- Managing Ligature Risks – OCN Credit 4 Learning
- Suicide Prevention Awareness (Education sector) CPD accredited
- Suicide Prevention Awareness (Custody sector) CPD accredited

I have achieved accreditation of a variety of courses for safer custody, managing suicide and self-harm, non-violent tactical communications, use of force and managing head injuries from physical interventions.

My company works throughout the UK and we have worked with over 200 schools regarding challenging behaviour, complex needs and/or physical intervention.

I have delivered a one-day custody awareness training day to the IPCC (Independent Police Complaints Commission) for approx. 30 of their staff regarding investigation of police custody complaints for searching of detainees and levels of observations.

I am a member, since 2019, of the IOPC (Independent Office for Police Conduct) virtual panel for custody 'Learning the lessons' publications. This does not affect my impartiality.

I have experience acting as an Expert Witness for prison and police custody, mental health, and education cases – suicide, self-harm, staff injuries, prisoner injuries, use of restraint equipment and use of force, points of law and safeguarding.

I have experience acting as an Expert Witness for use of force cases concerning police, prisons, schools, mental health units, SIA staff, and care settings.

I have experience working with discipline, civil, criminal and coroner cases and have provided evidence at court. I have been engaged by both the claimant and the defendant. I have also provided initial opinions via email or telephone conferences to both claimant and defendant legal teams.

I have experience working as an Expert Witness for the IOPC (Independent Office for Police Conduct) with a police custody case.

I have been engaged by the Northern Ireland Police Ombudsman.

I have worked with the BBC news, BBC Radio 4 and Radio 5 Live Investigation teams concerning investigations on challenging behaviour and use of force.

I completed the Bond Solon / Cardiff University Law School Expert Witness training over 2014 and 2015, registering as an Expert from 2016.

I have been involved, to varying degrees, with cases concerning safer custody, the use of force in police, prison, SIA, schools and mental health sectors, or station/hospital procedures. These include deaths and injuries.

I have published papers and e-books concerning points of law and practice involving the use of force. These include the titles:

- The management of challenging behavior and use of force: the effects of stress and associated risks
- The safer management of head and brain injuries
- The management of people who bite, scratch, spit or pull hair
- The safer use of calming and seclusion rooms / areas
- Managing mental health and behaviour
- The safer management and administration of medication to service users
- Understanding foreseeable risk
- The management of ligature risks - Preventing death by hanging

I acted as a volunteer Director for the London based company ‘Freedom From Abuse CIC’ for 2018-2019.

My Qualifications, awards and CPD include:

2012 to 2022 annual refreshers for all of my physical intervention and use of force trainer courses

2020: TrainerQuals level 3 Infection control trainer

2020: TrainerQuals level 3 Mental Capacity Act & Deprivation of Liberty (DOLS) trainer

2020: TrainerQuals level 3 Diabetes trainer

2020: TrainerQuals level 3 Safeguarding children trainer

2020: CPD UK membership.

2019: Specialist training provider award

2019: TrainerQuals level 3 Medication trainer

2019: TrainerQuals level 3 Mental health trainer

2019: Allergen awareness CPD

2019: COSHH iirsm

2019: PPE CPD

2019: TrainerQuals level 3 Epilepsy trainer

2018: Forensic & Expert Witness. 2018 Expert Witness Award for legal services for safer custody

2016 – date: OCN Credit 4 Learning Licensed Centre to deliver a variety of accredited courses concerning the use of force, challenging behaviour, suicide prevention, ligature risk management etc.

2014 & 2015: Expert Witness training with Bond Solon Legal Training

2014: Civil Procedure Rules Training

2014: NSPCC safeguarding train the trainer

2014: BTEC level 3 Safe & effective use of emergency response equipment trainer (requalify annually)

2014: BTEC level 3 Safe & effective use of restraint equipment trainer (requalify annually)

2014: Close Quarter Combat trainer

2013 – date: Health & safety instructor

2013-date: Fire safety instructor

2013 -date: Manual handling instructor

2013-date: Anaphylaxis instructor

2012: BTEC level 3 Self-Defence Instructor (requalify annually)

2012: BTEC level 3 Conflict Management Instructor (requalify annually)

2012: BTEC level 3 Physical Restraint Instructor (requalify annually)

2012 to date National Federation for Personal Safety (NFPS) Licensed centre

2012 – date: First aid and defibrillator instructor

2012: Winner. British Association of Women in Policing 'Excellence in Performance' Award. Included evidence for The Safer Detention & Handling of Detained Persons in Custody

2011: OCR level 4 PTLLS (Preparing to Teach in the Lifelong Learning Sector)

2011: Runner up National Business Continuity Awards for innovative training design & delivery for major incident management in policing

2010: Assistant Chief Constable Award for The Safer Detention & Handling of Detained Persons in Custody

2009: UK Training Awards winner for Professionalising Investigation (PIP)

2008: National (England) Training Awards winner for Professionalising Investigation (PIP)

2007: IOSH Managing Safely for Policing Services

1994: Home Office police law trainer

Examples of cases I have provided my services for include:

- Coroner court case concerning the death of a person in a mental health unit during a restraint;
- Coroner court cases concerning deaths during police stop and search procedures;
- Coroner court cases concerning choking deaths – police and the child sectors;
- Coroner court cases concerning deaths in custody;
- Coroner court case concerning mental ill health and missing persons procedures;
- Civil cases concerning police custody relating to head injuries and intoxication;
- Civil case concerning police response to a missing person, mental health and intoxication;
- Civil case concerning police release on bail and subsequent offences;
- Civil cases involving ligature deaths in prison custody;
- Civil cases concerning staff and prisoner assaults in prison custody;
- Civil cases concerning the use of force against children in schools;
- Civil cases concerning staff injured in schools during use of force incidents;
- Civil cases concerning SIA staff use of force;
- Criminal cases involving the use of force by SIA staff including manslaughter, GBH and ABH;
- Criminal case involving ABH accusations against a prison officer;
- Criminal case involving GBH complaint in police custody against an officer;
- Criminal case against custody Sergeant for ABH
- Criminal case involving the biting of a prison officer and ‘potting’ by prisoners;
- Criminal cases concerning assaults against emergency service staff, in mental health units and police patrol incidents;
- Criminal cases concerning the stress effects and how this influences behaviours during restraint;
- Police discipline case against officers accused of unnecessary use of force;

- Civil cases concerning issues around staff training/lack of staff training for custody roles;
- Human Rights case concerning police bail, mental ill health and murder;
- Criminal cases, and an appeal, concerning the evidential breath test procedure at police custody;
- Criminal cases and court of appeal case concerning excess alcohol/drugs – including fail to provide.

I have been engaged by legal teams representing complainants, defendants, coroner and the IOPC.

I have been engaged by the Police Ombudsman for Northern Ireland.

Legal teams representing the Prison Officer Associations and the Police Federation.

Since September 2020 I have been registered with the National Crime Agency as an Expert Advisor for major crime investigative support.

From December 2020 I have released an 8 hours on-line, level 2, certified course: Suicide Prevention Awareness Programme Module: Managing Ligature Risks. This can be found at: https://totaltrainltdeschool.thinkific.com/courses/suicide-prevention-managing-ligature-risks-in-the-secure-sector

This is designed for all secure settings including police, prison, immigration, secure transport, secure children accommodation, mental health units, hospitals, customs and military custody.

From December 2020 I have released a 6 hours on-line, level 2, de-escalation and conflict management course which can be found at: https://totaltrainltdeschool.thinkific.com/courses/de-escalation-and-conflict-management

This is designed for staff working within education, care, or the secure custody sector.

Concerning drink/drug driving and procedures:

Drink/Drug drive procedures are part of the custody portfolio due to the station procedures. All pre arrest contact is part of the 'safer custody' portfolio. The legislation under the Road Traffic Act is under the roads policing portfolio, but overlaps with the custody portfolio. I am not an 'expert' on the road policing portfolio issues, but I am on custody & safer custody procedure issues.

When I was operational all station and hospital procedures were conducted by a Sergeant, so every constable request was conducted by the Sergeant. This meant when I was on duty I handled all station and hospital procedures for my policing division.

There was hardly a day without a station procedure being conducted. I have easily completed in excess of 1000 evidential procedures. I have completed many roadside procedures over my career.

During my police service I also trained as an intoxilyser trainer, completing the train the trainer course at National Police Training, Harrogate. I trained other custody Sergeants how to use the intoxyliser and conduct station evidential procedures, including all the MGDD forms.

Following the adoption of 'safer custody' by 2006, the Sergeant was removed from the investigative process to keep them impartial and focused upon the care and detention of the detainee.

I taught constables the roadside procedures.

By 2006 I was teaching custody staff (Sergeants and detention officers) the safer custody aspects of dealing with drink & drug driver cases, and about the supervision of constables at the station conducting such procedures.

I remained involved in custody procedure training and policy until 2013, when I left policing. I have published an article in the Expert Witness magazine concerning drink and drug driving (November 2021).

Concerning Ligature Deaths:

Since 2006 I have trained staff concerning the management of ligature risks. This includes understanding what a ligature point is.

I have conducted custody ligature audits within police buildings and trained other staff how to conduct them.

I have conducted ligature audits within mental health community facilities and special schools.

I have trained trainers, and staff, within the secure sectors and care sectors for managing ligature risks and conducting ligature audits.

I have experience in providing expert witness reports for ligature deaths within the secure sectors and following police bail.

I have designed, and had accredited, a 24 hours, train the trainer, management of ligature risks and conducting ligature audit course. This course has been delivered within the UK and the Republic of Ireland.

I have been engaged by the Scottish Crown Office to investigate ligature deaths in the secure sector.

Disclosure

In 2013 I initiated a tribunal case against Cumbria Constabulary under the Equality Act for failure to make reasonable adjustments. The court found in my favour and I was awarded compensation, however this does not affect my impartiality and duty to the court. I have been engaged on police cases in a variety of ways. I have been engaged for reports by legal teams representing the member of the public claimant; I have been engaged for reports by legal teams/ police federation representing the police officer; I have been engaged for telephone conferences and initial email opinions by legal teams representing the Constabulary/ Professional Standards Departments; I have been engaged for a report by the IOPC (Independent Office for Police Conduct) and have provided training to the IPCC (Independent Police Complaints Commission) concerning custody, and designed an in house IPCC custody training session, for roll out to staff. I am engaged as a member of the IOPC learning the lessons consultation group. In August 2020 I designed and provided an e-learning input for Cumbria Constabulary concerning 'Adverse Childhood Experiences and Policing' as part of a wider programme commissioned by them with a business associate of mine. This input is also being used by him for UK wide use. In September 2020 I was accepted by the National Crime Agency (NCA) to be registered on their data base as a Major Crime Investigative Support Expert Advisor.

In May 2019, after giving evidence in a London coroner case concerning police actions, the coroner rang me to state there was no criticism of me or my evidence, and no adverse judicial comment, but she was going to exclude my evidence due to the issue of bias being raised, and as I was engaged else-where I was unable to return to court that date to clarify the position. This is the only incident of any of my evidence being excluded. The coroner confirmed that my litigation case against Cumbria Constabulary was of a private nature, which she did not require details of, and was excluding my evidence only because I was unable to return to the court to clarify the situation.

In February 2020 representation was made from the legal team representing the Metropolitan Police, concerning potential bias because of my litigation against Cumbria Constabulary. H M Coroner Andrew Harris, Senior Coroner, London Inner South

concluded: “The Senior Coroner summarised the gist of these concerns for Ms Caffrey and she provided a full account, which satisfied the senior coroner that there was no reason to suspect bias or a real basis for suspicion of bias in giving evidence in cases involving other police forces. It was noted that the litigation had no relation to operational decisions of police forces. The account contained information of a private nature.” And “Neither she nor the senior coroner see any reason that she cannot continue to be instructed in safer custody and restraint cases in future.”

Since this incident, I am not aware of any other representations having been made against my instruction for police cases, and have continued to be engaged by legal teams representing both police case claimants and defendants. There has been no adverse judicial comment made against me, or my evidence.