

SUPPLEMENTARY REPORT RE THE DEATH OF SHEKU BAYOH

ANALYSIS OF POTENTIAL FOR BREACH OF HEALTH AND SAFETY LEGISLATION

AGAINST INDIVIDUAL OFFICERS

AGAINST THE POLICE SERVICE OF SCOTLAND

Consideration has been given as to whether there is sufficient evidence to consider criminality on the part of the office of The Chief Constable of The Police service of Scotland or on the part of any individual police officer under the Health and Safety at Work Act 1974.

Relevant sections of the Health and Safety at Work Act 1974:

S3(1): It shall be the duty of every employer to conduct his undertaking in such a way as to ensure so far as reasonably practicable that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health and safety.

S33 (1) provides that it is an offence for a person (a) to fail to discharge a duty to which he is subject by virtue of section 3(1).

This Act has applied to the Chief Constable of police forces in the UK since the enactment of the Police (Health and Safety) Act 1997.

In this case when police officers first attended the scene they issued verbal commands to the now deceased Sheku Bayoh to stop and they used their incapacitant sprays and/or batons in support of those verbal communications. When he failed to respond, these officers then deployed CS and PAVA spray, to no effect. When further officers arrived on the scene they too issued orders and one of them also deployed CS spray. When Sheku Bayoh turned and assaulted PC Short, he was struck by PC Tomlinson using baton blows to the head and arms before being brought to the ground in a 'bear hug' by PC Walker. He was

then restrained for around 4 minutes by up to seven officers before being found to be unresponsive.

In terms of how that legislation might apply to the death of Sheku Bayoh, the risks to which Mr Bayoh was exposed could relate to the method of engagement by the officers including the use of sprays and batons, the subsequent taking to the ground and method of restraint of Mr Bayoh by police officers. The method whereby the office of Chief Constable of the Police Service of Scotland could ensure, so far as reasonably practicable reasonably that Mr Bayoh (not a person in his employment) who may be affected by those risks, was not exposed to such risks was to ensure that adequate training was delivered to the officers. In particular, in this case, the question is whether the training provided to the officers was sufficient for them to recognise and know how to deal with a person suffering from drug induced psychosis or “excited delirium” as it was then known in PSOS training, and taking this into account in the context of their method of approach and restraint.

In the current case two expert witnesses have expressed some concern about what they see as gaps in the police training: Professor Eddleston and Martin Graves.

Professor Eddleston

Firstly , in his report dated 2 June 2017, Professor Michael Eddleston’s expressed concerns in paragraphs 18 and 21 – 23, (there are two paragraphs 23) about the question of whether the PSOS Use of Force Standard Operating Procedure (SOP) then in place at the time of Mr Bayoh’s death adequately covered the situation in which the officers found themselves. These concerns are set out in full below:

- 18) Within the PS UoF SOP, drug-induced psychosis is considered in a separate section (21.3), under the title ‘Excited Delirium’ (p27). The guidance offered to officers dealing with patients with mental health issues, including schizophrenic psychosis, is not provided to officers dealing with patients with drug induced psychosis. This is unfortunate since the principles are the same.

There can be differences between psychosis due to stimulant drugs and psychosis due to schizophrenia in that the sympathomimetic effect of stimulant drugs (often amphetamines, cathinones, cocaine) can cause transient increased energy, strength, and stamina, directed into struggling and violence. Because patients cannot understand what is happening, they will

struggle forcefully for as long as they have the strength. They are unlikely to understand that they cannot win and calm down voluntarily. During restraint, stimulant drug users are at risk of dysrhythmias such as ventricular fibrillation.

The only practical advice offered to officers is that “the use of handcuffs, batons and CS Spray are all likely to be ineffective” (21.3.5) and that such patients should “be taken directly to hospital once control has been established” (21.3.8). However, this transfer may be too late for some patients.

- 21) The situation in Kirkcaldy on the morning of the 3rd May was stressful for the police officers. They believed that it might be a terrorist attack targeting them during their work. SB had already attacked one of his friends and been seen with a large knife while attacking cars.

However, SB is not reported to have been aggressive towards, or attacked, any of the police officers until he had been sprayed three times (a level 5 response to level 3 resistance, Use of Force Framework, p13) and had three police officers facing him in a group. At that point, he seemed to believe that he was being threatened and then unfortunately attacked Officer D. He was not seen to be bearing a knife, although it was not possible for the police to exclude the possibility that he had it hidden on his body.

- 22) If the first police officers on the scene had realised that My Bayoh was psychotic, consistent with their observations that he was ignoring them and looking crazy, and had followed Police Scotland advice for dealing with psychotic patients, the outcome might have been different.

Ideally, open empathic questioning, while offering space to SB to keep walking, might have calmed the situation and prevented the attack or the need to restrain him physically until submission. In the meantime, an ambulance could have been called to help take SB to hospital.

If this conservative approach had been ineffective, a combined physical and chemical restraint approach would have been necessary. At the very least, an ambulance and paramedics should have been present when physical restraint was initiated. This would have allowed paramedics to rapidly gain intravenous access to administer sedative diazepam and/or haloperidol under the guidance if necessary from the local emergency department. At best, the restraint could have been delayed until a doctor had come urgently from the emergency department to help control the situation, allowing the administration of fast-acting ketamine.

- 23) Overall, the situation on that morning was difficult and fast moving. A powerfully built psychotic man had been violent to people and cars. He did not respond to clear police instructions.

Unfortunately, his psychosis prevented him from understanding the situation or the instructions. His paranoid thoughts caused him to attack the police, resulting in physical restraint until submission, without the aid of medicines to induce sedation administered by paramedical or medical staff. At the point physical restraint was started, his prognosis was poor.

- 23) Psychosis is a well-recognised complication of stimulant drug use with a poor prognosis when public safety requires physical restraint without medical support. However, revision of the PS UoF SOP, to present psychosis from schizophrenia and stimulant drugs together, as well as

additional training in the assessment and management of such patients, may reduce the risk of further deaths from stimulant drug toxicity while under restraint.

A joint discussion between police and emergency medicine physicians in Scotland and UK might increase understanding of how to manage these complicated patients and refine the current guidance for the benefit of the psychotic patients and police officers.

Professor Eddleston was referring to

Pro 329 PSOS Use of Force SOP

Which was in force at the time of Sheku Bayoh's death. It was established in evidence that the Use of Force SOP was not referred to in Officer Safety Training (OST). The witness James Young, at that time Head of Officer Safety Training at Police College, Jackton, spoke of the SOP as a policy document available on the Police Intranet and not one to which officers would readily refer. The training manual therefore contained the necessary guidance in detail.

Section 8 of the SOP makes reference to psychosis and in particular to schizophrenia as the possible cause of psychosis. There is no mention in section 8 of the SOP to the possibility that stimulant drug use could produce the same result and render the person who ingested the drugs psychotic.

The guidance contained in section 8.7 of the SOP is that while officers should not try to diagnose the specific illness, "it is important that there is a realisation that a person has some form of mental health issue or condition".

The suggested methods of dealing with such a person (in this part of the SOP) include staying calm, giving the person space so as not to put them under pressure, only one person speaking to the subject to establish a rapport, showing an interest and expressing empathy, trying to find out what had caused the upset.

Section 21 under the heading of "medical conditions and implications" deals with the risks of positional asphyxia (para 21.2) and excited delirium (para 21.3). Under this section, a description is provided as to how excited delirium might

manifest is included: – extreme violence accompanied by bizarre, manic and purposeless behaviour). At 21.3.8 (in bold) it states: **“A person suspected of suffering from this condition is to be taken directly to hospital once control has been established”**

Professor Eddleston’s criticism of the SOP is that the guidance did not make the link between psychosis caused by mental illness and psychosis due to drug ingestion. He considered that the police officers attending had some signs that Mr Bayoh was psychotic, namely that he was not responding to them and looking “crazy.” However he was critical that the SOP made no link between the guidance for mental health conditions and the guidance for persons suffering from excited delirium.

Professor Eddleston was not provided with a copy of the training manual that was in place at the time, or with any other training materials.

It has been established in the course of this investigation that the content of police training as at 3 May 2015 was based on the content of

PRO 675 Probationer Training Officer Safety Training Manual version 2.00

This is described by the witness Young as the Scottish Police College's central reference point for probationer officers for the Officer Safety Training and the basis for all officer safety training in Police Scotland. The manual provides an awareness of the general OST techniques that officers may require to use in the operational environment. It consists of nine modules covering officer safety theory, empty hand techniques, rigid handcuffs, fast straps, violent prisoner transfer, straight baton, incapacitant spray, cordons and spit hood.

It was further established that the way this information was imparted to police officers during their probationer training was by way of a

Pro 859 PowerPoint presentation

the content of which mirrored the content of the training manual. This PowerPoint had been used by trainers in the legacy Fife Constabulary from 2004 until 2015.

The relevant section of the training manual is in module 1 on page 24. This provides that 'excited delirium' is a condition when a subject exhibits violent behaviour in a bizarre and manic way. It goes on to say that it is a rare form of severe mania which may form part of the spectrum of manic depressive psychosis and chronic schizophrenia, characterised by constant, purposeless, often violent activity with incoherent or meaningless speech and hallucinations with paranoid delusions.

In terms of possible causes of the condition, the guidance includes reference to drug intoxication, alcohol intoxication *or psychiatric illness*, with cocaine being the most commonly associated drug with this condition. This part of the manual repeats the guidance from the SOP that the person with such a condition should be treated as a medical emergency and taken to hospital once control has been established. There is no reference in this section of the training manual to the empathetic approach recommended by Professor Eddleston, and which featured in the SOP in relation to someone suffering from mental health.

The OST expert, witness Graves considered that what Professor Eddleston had to say related to mental illness in a hospital environment and this was not practical in an open area.

In the appendices to his own report (Pro 894) witness Graves provided a copy of the training manual from England for which he was partly responsible for writing. It is of note that while this provides more detail about the nature of Acute Behavioural Disturbance (the newer terms for what was formerly known as excited delirium), essentially the advice about recognising and dealing with it is not markedly different from that in the PSOS version at the time (PRO 675) in that it deals with the dangers of restraint and urges immediate medical intervention. Significantly there is no suggestion of the kind of empathetic approach specific to such a subject as advocated by Prof Eddleston.

In terms of what the legacy Fife Constabulary training involved around these issues it is of note that

PRO 801 Fife Constabulary Use of Force Standard Operating Procedure contains word for word the same information about positional asphyxia and excited delirium as is contained in

PRO 329 Police Scotland Use of Force SOP.

Police Scotland could not provide PIRC with any training manuals or materials relating to Fife Constabulary predating 2008.

The 2008 Fife SOP (Pro 801) was written by a PC Stephen Boyd, who was interviewed by PIRC. He stated that the SOP was his own work but in particular the sections about 'mental health issues' and 'medical implications' were based on the national guidance documents available to police in both Scotland and England at the time.

The witness Young highlighted that SOPs could be accessed by officers online on the Force intranet, but this would be a voluntary activity, whereas the face to face training regime of the OST Probationer and refresher courses were the appropriate means to impart the necessary guidance.

Further, according to the evidence of numerous trainers, officers who attended (bi-annually until 2013 and thereafter annually) would have been reminded of the issues of excited delirium and positional asphyxia during the course of their one day OST refresher training. These topics were included in a checklist used by trainers in the course of the one day refresher course and all the trainers interviewed stated that these conditions were referred to in the course of demonstrating techniques.

The witness Martin Graves, an expert witness in relation to Officer Safety Training was asked at precognition to provide opinion on whether the content of the Training materials in place at the time (2015) provided the officers with enough information to allow them to identify the condition of excited delirium

(now referred to as Acute Behavioural Disturbance). He thought that while somewhat dated, the content of the training was adequate on paper (with the proviso that it is difficult to know without seeing and hearing how the training is delivered, and what parts were emphasised). He commented on the absence of wording to highlight to police officers unusual or out of the ordinary behaviour to identify this condition, although in fact the section on Excited Delirium on page 24 of the Manual starts with the sentence *"This is when a subject exhibits violent behaviour in a bizarre and manic way"*.

Professor Eddleston's suggests that had the police recognised that Mr Bayoh was psychotic they might have followed the suggested methods of dealing with a subject suffering a mental health condition, namely adopting a more empathetic approach and that may have led to a different outcome for the deceased. In order for the first officers to recognise that Mr Bayoh was psychotic they would had to have been in possession of more information about him than was made available to them en route to the locus.

On page 26 of his report Martin Graves states (para c.) that at the time of the first officers' arrival he does not believe there was any direct evidence to point to Mr Bayoh suffering from ABD. That soon changed once the officers had engaged with him and when they found him unresponsive both to their orders to incapacitant sprays such that the picture was or ought to have become evident. However Mr Graves took no issue with the initial 'hard' approach by the police officers in light of their assessment that he was a high risk, given the information of a large male wielding a very large knife. At that stage all that they knew was that they were dealing with a high risk situation of a knife wielding male walking the street and albeit the knife was not evidently in his possession on their arrival. The training materials available provided guidance to identify this reported person as a high risk, because he had a large knife and had been chasing persons with it.

It is the opinion of Mr Graves that when it became apparent to the officers that Mr Bayoh was suffering from ABD an ambulance ought to have been called immediately and he is somewhat critical of PC Smith, himself an OS Trainer for seeming to consider but then initially rule out this possibility. If there was a

delay in summoning assistance it was because PC Smith did not immediately call for an ambulance when he first considered that Mr Bayoh was suffering from “excited delirium” or ABD. The training materials were not deficient in this respect as they stated clearly that such a person should be treated as a medical emergency.

However, against that, Mr Graves states that from the information provided by many witnesses about his conduct in the short timeframe before the police arrived, he thought that Mr Bayoh was unlikely to have been “talked down” from the outset given his demeanour. There is evidence from friends and neighbours who were non-threatening to Mr Bayoh that they tried to persuade him to stop and put down the knife and were unsuccessful. It is questionable whether having such advice to officers to adopt a more empathetic approach to a person suffering from ABD would be reasonably practical, unless it was also balanced with the obvious risks attendant to such an approach. Ultimately the guidance to police officers must put their own safety first. Control had to be achieved by the police in order that they could deal with Mr Bayoh. The evidence would suggest therefore that the training in place at the time provided so far as reasonably practicable, PSOS had provided its officers with adequate training to identify the risks.

Martin Graves states that the content of the training at that time was somewhat outdated in terms of the terminology used (for example ‘excited delirium’ rather than Acute Behavioural Disturbance), but overall he could not point to any obvious and significant gap in content that might have played a part in this case. He obviously thought that the police training in England was superior to that examined by him, although he might well say that, given that he was the author of much of the English version, which was certainly more detailed. The training modules to which he refers are included as appendices to his report (Pro 894). Those training modules attached to his report as appendices make no reference to the type of advice now being suggested by Prof Eddleston – namely that a more empathetic approach might be more appropriate, or, at the very least, for an ambulance to have been called from the outset so that once the police had gained control, medical intervention would have been available.

He similarly considered that the content of the training about positional asphyxia was brief but that it contained the necessary information.

There are competing issues of health and safety that are specific to Policing. These are set out in a Guidance Note issued by HSE: "Striking the balance between operation and health and safety duties in the Police Service". This note explains the serious dangers of policing and how police officers take risks in dealing with violent crime to secure the safety of the wider public. This guidance note acknowledges that officers are sent into dangerous situations and that they have to respond to fast moving situations when there is sometimes incomplete information about the incident.

Professor Eddleston's view is from the point of view about the limitations of the Use of Force SOP does not reflect the practical reality for the officers sent out to deal with the report of Mr Bayoh. Would it be reasonably practicable for police training to provide specific advice to police officers that an empathetic approach should be considered for persons suffering from ABD? How does that balance with the duty of care on the Force for the health and safety of its workforce? There are competing health and safety issues here.

The question is what reasonably practicably could the training have included that would have satisfied Professor Eddleston's issue? To suggest that the training ought to include a suggestion of somehow 'talking down' or rationalising with the person might put the officers in greater danger than their 'hard', 'not taking any risks' approach.

Professor Eddleston also suggested that the death of Mr Bayoh may have been avoided had an ambulance been called in advance of the officers engaging with Mr Bayoh. This pre-supposes that there was enough information to make such a call.

In January 2017 the report of Independent review of deaths and serious incidents in police custody by Dame Eilish Angiolini was published.

This review was commissioned by the then Home Secretary in July 2015, some months after the death of Mr Bayoh.

Paragraph 13 of the Executive Summary provides:

National policing policy practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk.

It is not clear from the evidence gathered in this case to date, the extent to which that “widely evident position” was known in May 2015. However, as has been assessed in the analysis of evidence of this case, the officers involved in the engagement and restraint of Mr Bayoh were not in a position to recognise that he was suffering from such psychosis when they first encountered him and the signs became apparent or ought to have become apparent as they dealt with him. Thereafter, with his violent response to their approach, the taking down to the ground and restraint was the only option available to the officers and the OST expert could not take issue with such action.

At paras 2.65 and 2.6 Dame Angiolini advocated that police officers should be encouraged to use de-escalating techniques but acknowledged that these might not always be appropriate in circumstances of danger or urgency.

The report discusses the question of excited delirium/ ABD and (at para 2.48) “an understanding of these mechanisms and of the physiological consequences that flow where physical restraint is used on those who present a high risk has developed only slowly.”

In this context the initial attending officers had received some but not all of the information that may have led them to think that Mr Bayoh was suffering from ABD. They could see and assess his demeanour at the locus however and those observations ought to have contributed to some recognition of the emerging picture.

Meanwhile, those in the command and control room had some more information about the type of bizarre behaviour reported by members of the public that was not passed to those first officers, but they did not have the benefit of seeing at first hand the type of behaviour that eventually led at least PC Smith to consider ABD.

It is submitted that neither group of officers/ police staff had the full picture at that time on which to make the assessment, at least at the outset, that Mr Bayoh was suffering from ABD. The position ought to have become more evident to the police officers first on the scene as events unfolded, by which time they were so actively engaged in restraining him that none of them were in a position to act to summon medical help until he was under control.

What were the actions that the PSOS could have taken that were reasonably practicable to have prevented Mr Bayoh being exposed to the risks of restraint before the arrival of an ambulance? It is submitted that the guidance in the training manual at the time provided the tools to the officers to take decisions that they had to make. It is conceded that they did have the option to take a more empathetic approach, and although not specific to persons suffering from ABD, a range of communication techniques are put forward more generally in the training manual. However, their obligation was to deal with the reported knife carrying male in a way that protected their own safety and that of the public.

Martin Graves

At page 23 of his report, Mr Graves made comments about three aspects of police training.

The first matter related to

PRO 547 Module 1 Officer Safety Theory

It has been established this was part of a legacy Fife Constabulary training manual from pre 2012 and was no longer in force at the time of the incident in

2015. Evidence from training records for each officer showed that they had all received training or refresher training under the Pro 675 Probationer Training Officer Safety Training Manual version 2.00. His comments in this regard are therefore irrelevant to the current consideration.

The second matter with which he took issue was the lack of anything in the training manual about the potential medical implications of strikes. Mr Graves was asked about the efficacy of that training in relation to baton use, particularly in light of the evidence that PC Tomlinson deployed his baton and struck the now deceased on the head more than once. These blows did not contribute to the cause of death of Mr Bayoh, but there can be little doubt that such blows exposed a risk to his health and safety. Martin Graves was critical of the absence in the training manual (PRO 675) of any guidance to officers that striking a subject to the head (or indeed other vulnerable parts of the body) carried greater risk of significant injury or indeed, death.

However there is contained on page 84 of the PRO 329 Use of Force SOP a trauma chart in which the head area would have been highlighted in red.

The evidence from trainers is that the Use of Force SOP was more of a policy document, not regularly referred to during training and that the training manual was the point of reference instead. Indeed James Young, who was the lead trainer for OST at the time thought that the Use of Force SOP was not always read and for this reason he removed reference to medical or mental health considerations from the SOP when he came to revise it in 2016. For the same reason then, the trauma chart may have been better placed in the training manual rather than in the Use of Force SOP. However given that there is some evidence of reference to an escalating trauma chart in the SOP the Police can point to some reference in their documentation to such guidance.

The third matter he raised (page 24 of his report) was that the PRO 678 SPELS training manual was inconsistent with

PRO 675 Probationer Training Officer Safety Training Manual version 2.00
in respect of advice that positional asphyxia could occur in those who were restrained in a prone position, which was not completely accurate.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

S7: It shall be the duty of every employee while at work—

- (a) to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work; and
- (b) as regards any duty or requirement imposed on his employer or any other person by or under any of the relevant statutory provisions, to co-operate with him so far as is necessary to enable that duty or requirement to be performed or complied with.

33(1) It is an offence for a person—

- (a) to fail to discharge a duty to which he is subject by virtue of section 7

This section of the Act might apply if one of the police officers involved with Mr Bayoh had deviated markedly from training in the way that they restrained him or dealt with him. [REDACTED]

ANALYSIS OF EVIDENCE RE POTENTIAL FOR CORPORATE HOMICIDE

Corporate Manslaughter and Corporate Homicide Act 2007

S1 provides that:

(1)(a) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised causes a person's death; and

(b) Amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

(2)(c) The organisations to which this section applies include a police force.

(3) An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1)

[REDACTED]

S 2 provides that:

"*relevant duty of care*", in relation to an organisation means any of the following duties owed by it under the law of negligence and includes:

(d) A duty owed to a person who, by reason of being a person within subsection (2) is someone for whose safety the organisation is responsible.

Subsection (2) applies to a person if–

(a) he is detained at a custodial institution or in a custody area at a court [a police station or customs premises]

(aa) he is detained in service custody premises;

(b) he is detained at a removal centre [, a short-term holding facility or in pre-departure accommodation];

(c) he is being transported in a vehicle, or being held in any premises, in pursuance of prison escort arrangements or immigration escort arrangements;

(d) he is living in secure accommodation in which he has been placed;

(e) he is a detained patient.

It would appear that the now deceased Bayoh was not a person defined in section 2(2) of the Act as he was not detained in any of the premises described in Section 2(2)

And furthermore S5 provides the following exclusion to liability in that:

(1)(a) Any duty of care owed by a public authority in respect of operations within subsection (2) is not a "relevant duty of care" if

(2) Operations are within this subsection if–

(a) they are operations for dealing with terrorism, civil unrest or serious disorder,

(b) they involve the carrying on of policing or law–enforcement activities, and

(c) Officers or employees of the public authority in question come under attack, or face the threat of attack or violent resistance, in the course of the operations.

In the present case the police were responding to several reports of Mr Bayoh carrying a knife and attacking cars. He was non-compliant with officers and violent. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

In terms of section 5(2)(a) the Act does not provide an interpretation of "serious disorder" [REDACTED]

[REDACTED]

S5(2) (b) the police officers in attendance were involved in law enforcement at the time and

S 5(2) (c) Short came under attack and there was violent resistance by Mr Bayoh thereafter.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]