1 Thursday, 11 May 2023
2 (10.00 am)
3 LORD BRACADALE: Good morning, Dr Lipsedge. Can you see me
4 all right on your screen? (Pause). I don't think I am
5 able to hear you, Dr Lipsedge. Could you just speak
6 again?
7 THE WITNESS: Yes, I can see you.
8 LORD BRACADALE: Thank you. I am Lord Bracadale, I am the
9 chair of the Public Inquiry and I am accompanied by my
10 Assessors Mr Raju Bhatt and Mr Michael Fuller. Before
11 your evidence begins would you please say the words of
12 the affirmation after me.
13 DR MAURICE LIPSEDGE (affirmed)
14 (By video link)
15 LORD BRACADALE: Your evidence will be led by Ms Grahame KC
16 who is the senior counsel to the Inquiry. We usually
17 have a break at about 11.30 am, but if you wish a break
18 earlier, or indeed at any time during your evidence,
19 just tell Ms Grahame and we can take a break then.
20 Ms Grahame should now appear on your screen.
21 Questions from MS GRAHAME
22 MS GRAHAME: Thank you. Good morning Dr Lipsedge.
23 A. Good morning Ms Grahame.
24 Q. Are you able to hear me reasonably well?
25 A. Yes. I can hear you.

1 Q. I think you sound quite quiet to me, so I'm going to ask
2 the tech team behind the scenes maybe to increase the
3 volume slightly. You are Maurice Lipsedge?
4 A. That is correct.
5 Q. Thank you. What age are you, Dr Lipsedge?
6 A. Sorry, I didn't hear that question.
7 Q. What age are you, Dr Lipsedge?
8 A. I am 86.
9 Q. Again, I think I will have to ask the tech team behind
10 the scenes to increase the volume in relation to your
11 microphone. Did you say you are 86?
12 A. 86.
13 Q. That sounds a lot better now. You were a consultant
14 psychiatrist during your career, is that correct?
15 A. That is right. Consultant psychiatrist in what is
16 called general adult psychiatry.
17 Q. Were you based in London?
18 A. I started in -- working in Hackney, I was attached to
19 St Bartholomew's Hospital and then in 1980 I moved to
20 Guy's Hospital, and I was responsible for an area --
21 a rather deprived inner city area Deptford and New Cross
22 where most of my patients suffered from schizophrenia or
23 what was then called manic depressive disorder.
24 Q. We can hear some feedback on the screen and I wondered
25 is there a phone or some sort of technology on in your

1 room other than the screen that you are speaking to me
2 on?
3 A. No.
4 Q. No phone or anything like that in the room?
5 A. No. No, my mobile phone is switched off for sound.
6 Shall I turn it off altogether?
7 Q. Try turning it off completely and we will see if that
8 helps. It is just that everything you say I can hear
9 an echo.
10 A. Right. (Pause). I have turned the mobile phone off.
11 Q. Thank you very much. It still seems to be producing
12 a slight echo. Is there anything else in the room at
13 all?
14 A. No.
15 Q. That sounds a bit better, could you say something?
16 A. Yes, I have turned my mobile phone off completely. Is
17 there still an echo?
18 LORD BRACADALE: Shall we see if the AV people can make any
19 adjustments. Dr Lipsedge, we are going to break off for
20 a moment to see if our technical people can improve the
21 situation. So somebody will come back to you shortly to
22 tell you what is going to happen. Thank you.
23 (10.07 am)
24 (A short break)
25 (10.48 am)

1 LORD BRACADALE: Dr Lipsedge I am very sorry for the delay.
2 I hope that the difficulty has now been resolved. What
3 I propose to do is we shall sit for an hour until 11.45,
4 we'll take a 15-minute break and then we'll sit for
5 an hour from 12 o'clock until 1 o'clock, but that's
6 subject -- if you want another break during that time
7 just let us know.
8 So I will hand you over to Ms Grahame again.
9 Ms Grahame.
10 MS GRAHAME: Thank you. Good morning again, Dr Lipsedge.
11 A. Good morning Ms Grahame.
12 Q. Good morning. Before the break you said that you were
13 Dr Maurice Lipsedge; is that correct?
14 A. That is correct, yes.
15 Q. And you were 86 years of age.
16 A. That is right.
17 Q. We were just going to have a discussion about your
18 career. You have been a consultant psychiatrist?
19 A. Yes.
20 Q. Now, you've provided the Inquiry with a detailed
21 statement, haven't you?
22 A. Yes. That's correct.
23 Q. And that was taken on 22 and 30 December last year by
24 a member of the Inquiry team?
25 A. Yes. I'm not sure of the dates but~...

1 Q. Don't worry about the dates. I don't need you to
2 confirm that, but you had an opportunity to consider
3 your statement, and you then --
4 A. Yes.
5 Q. -- signed it for us and sent it back to the Inquiry; is
6 that right?
7 A. That is correct.
8 Q. Just for my purposes, you know that you've stated that
9 the contents of your statement are true; that is correct
10 isn't it?
11 A. Yes, that's correct.
12 Q. And you understand, doctor, that the statement may be
13 part of the evidence for the Inquiry, that the Chair
14 will be able to read it in detail?
15 A. Yes.
16 Q. And you also know that it is going to be published on
17 our website so that others can also read the whole
18 contents of your statement?
19 A. Yes. I understand.
20 Q. It was on the basis of that understanding that you
21 signed it and sent it back to the Inquiry?
22 A. That is correct.
23 Q. Excellent. In addition, you've also sent us some
24 articles and documents which are referred to in your
25 statement that the Chair will have available to him to

1 look at?
2 A. Yes.
3 Q. Thank you. So should the Chair understand that in
4 addition to the evidence that you give us today, he
5 should also have regard to the statement and the
6 documents that are referred to in your statement and
7 that you've referred to?
8 A. Yes --
9 Q. Lovely, thank you.
10 A. -- that is correct.
11 Q. Thank you very much. For the members of the public that
12 might be listening, Dr Lipsedge, I understand -- I would
13 like to talk a little about your career and I understand
14 that you have been a consultant for -- you were
15 a consultant since 1974 in general adult psychiatry.
16 A. That is correct.
17 Q. And you briefly talked about working at different
18 hospitals, and you retired in 2001, is that correct?
19 A. I retired from the National Health Service then. I was
20 65.
21 Q. Right.
22 A. But I continued to work.
23 Q. And as I understand it, you've continued to work doing
24 medical legal work?
25 A. Medical legal work and working in occupational medicine,

1 occupational psychiatry.
2 Q. How long did you continue working after your retiral
3 from the NHS?
4 A. Oh, until very recently. The last work I did of any
5 significance I think was giving evidence at the inquest
6 into the death of Leon Briggs. That was about two years
7 ago.
8 Q. Thank you.
9 A. But I've continued to teach since then and I'm an
10 emeritus consultant at the Maudsley Hospital. And I am
11 what is called a visiting consultant at a medium secure
12 psychiatric unit and I have continued to do that until
13 the present. I do that work remotely and I attend the
14 ward round of the consultant in charge, Dr Raj Mohan.
15 Q. Thank you. You have also been called upon to assist in
16 relation to work that has been done in relation to
17 excited delirium and acute behavioural disorder, is that
18 correct?
19 A. That is correct. That was a committee or a subcommittee
20 set up by the Royal College of Psychiatrists to look
21 into -- really into the concept and practice associated
22 with excited delirium and acute behavioural disturbance.
23 Q. Am I correct in saying that acute behavioural
24 disturbance is sometimes known as ABD?
25 A. That's correct.

1 Q. You have also written articles about the topic?
2 A. Yes, the two -- the two articles really are -- the first
3 one was a critique of the concept of excited delirium,
4 and that appeared in a journal called Medicine, Science
5 and the Law in 2016, and then more recently, together
6 with Terry McGuinness, a barrister -- and he was the
7 senior author -- with Terry McGuinness we wrote another
8 critique of excited delirium and explained its
9 historical development, mainly within the United States.
10 Q. Was that published last year?
11 A. Yes. In 2022 in a journal called
12 Psychological Medicine.
13 Q. Are those journals respected journals in your field,
14 Medicine, Science and the Law and the --
15 A. Yes. And Psychological Medicine. Yes. They are highly
16 respected journals.
17 Q. Thank you. As I look at your statement, and I don't
18 need you to look at it, but you've given the Chair some
19 detailed information about inquests and cases that you
20 have been involved in where you have been asked to
21 provide expert opinion and evidence in relation to that.
22 A. That's correct and that goes back a long time, about
23 40 years. I'd be invited to give evidence on behalf of
24 the families of men who had died in custody, the charity
25 Inquest, and the legal firm Bhatt Murphy would be

1 involved in inviting me to give a psychiatric opinion in
2 those cases.
3 Q. Thank you. You've detailed those in your Inquiry
4 statement for the Chair to consider?
5 A. Yes. I have.
6 Q. Thank you. A number of these, did they involve the
7 deaths of young black men?
8 A. Yes. They were all young black men. One of them,
9 David Bennett, died in a National Health Service medium
10 secure hospital. The others died in police custody.
11 Q. And some have involved restraint in police custody by
12 police officers?
13 A. Yes, they all involved restraint, including the death of
14 David Bennett in hospital.
15 Q. Right.
16 A. He was restrained by nurses, not by the police.
17 Q. Was one of them called Roger Sylvester?
18 A. Roger Sylvester, yes.
19 Q. And that was an inquest in 2003, as I understand?
20 A. That is correct. If I can add, the first one was
21 Mr Winston Rose, who was mentally ill, was detained
22 under section 136 of the English Mental Health Act and
23 was being transported to a police station in a Bedford
24 van. He was being transported in the well of the van
25 with the feet of the police officers sort of containing

1 him while he was on the floor.
2 And to my mind the most important one from the point
3 of view excited delirium was Ibrahima Sey. Ms Grahame
4 if I could say a few words about that --
5 Q. Please do, yes.
6 A. -- and about the inquest.
7 Ibrahima Sey was an asylum seeker from the Gambia.
8 He was a young man, I think in his 30s. He had an
9 undoubted episode of mental illness and a previous
10 history of mental illness and he became very disturbed,
11 and his wife was very frightened of him and had to
12 escape from their home. Police were called, but also
13 his best friend from the Gambia was called and the best
14 friend was able to calm him down and he was transported
15 to Ilford police station in a reasonably calm state.
16 When they got to the yard of the police station the
17 friend was not allowed to accompany him into the station
18 and at that point Mr Sey became very suspicious and
19 frightened, and tried to escape and he was restrained by
20 a number of officers. He was sprayed with CS gas but
21 it's the physical restraint that was significant in that
22 case, and he died in custody.
23 Now, the reason I am emphasising that particular
24 case is that at the inquest the psychiatrist for the
25 police, Dr Kennedy, he said that he believed that Mr Sey

1 died from what he called Bell's mania. The literature
2 on excited delirium often invokes Bell's mania as a sort
3 of historical predecessor of the phenomenon. I think
4 incorrectly. Very briefly, Luther Bell was
5 a psychiatrist at a hospital in Massachusetts in the
6 United States in the 1840s and he described a number of
7 patients who were extremely excited and who were also
8 delirious, and they all died, but they died after many
9 days, up to 30 days, of excitement, and I think the
10 shortest length of time before death was something like
11 ten days.
12 So Mr Sey had been disturbed for a matter of hours
13 so to ascribe his death to Bell's mania was incorrect
14 because Bell's mania, as I just said, described death
15 after ten days and this was a matter of several hours in
16 Mr Sey's case.
17 That provoked my interest in the possible misuse of
18 psychiatric terms in the context of deaths in custody,
19 where it seemed to be claimed that the primary cause of
20 death was a psychiatric disorder rather than restraint
21 or other factors.
22 Q. I think you explained to the Chair in your statement
23 that at the inquest for Mr Sey the suggestion that the
24 cause of death was a psychiatric disorder was not
25 accepted by the coroner and the jury returned a verdict

1 of unlawful killing; is that correct?
2 A. That's correct, that is correct.
3 Q. Thank you. In addition I think we can see in your
4 statement that you mention and provide the Chair with
5 details regarding Leon Briggs, who you've already
6 mentioned.
7 A. Yes.
8 Q. For those who wish to look at it this is SBPI 00298.
9 That is a number you don't you need to worry yourself
10 with, that it is just for anyone who wants to look at it
11 and we see that you have given some information to the
12 Chair about the Leon Briggs inquest at paragraph 5 of
13 your statement.
14 A. Yes. I felt that the case of --
15 Q. I am interested in this and the relevance it may have to
16 the circumstances that we are looking at in this
17 Inquiry.
18 A. Yes. The relevance for me was that this was another
19 young black man who had been behaving in a very -- in
20 a public place in a very bizarre way. He did not have
21 a weapon, he did not harm anybody, but he was jumping in
22 front of cars, leaping on cars, taking risks with his
23 own life and was clearly very disturbed and a member of
24 the public called the emergency services and she
25 actually emphasised that the individual needed both

1 an ambulance and help from the police.
2 Now, the first available police officers were a team
3 of armed officers, and they, without attempting to have
4 a conversation with Mr Briggs, restrained him and
5 restrained him in a highly unsatisfactory way. I must
6 add that the cause of the obvious behavioural
7 disturbance in Mr Briggs' case was the fact that he had
8 taken large amounts of amphetamine.
9 Q. If we can have on the screen the next page of the
10 statement, please. Just so that people can follow this,
11 Dr Lipsedge. You use the word "de-escalation" and say
12 there was no attempt at de-escalation?
13 A. Yes.
14 Q. Then in paragraph 6 of your statement you talk about if
15 it had been a sort of old-fashioned policeman on the
16 beat. Can you give us a little bit more detail about
17 that?
18 A. Yes, Mr Briggs was clearly disturbed, but he hadn't
19 harmed anybody, he hadn't attempted to harm anybody, he
20 certainly wasn't armed. He appeared bewildered and very
21 frightened, and he had been in a shop where -- a shop
22 where the shopkeeper recognised him. They hadn't had
23 a satisfactory conversation but it was clear that it was
24 possible to engage in some sort of dialogue with him.
25 And rather than restrain him physically, the first step,

1 in my opinion -- and I think the coroner agreed with
2 this -- the first step should have been a verbal
3 de-escalation. That is to say, an attempt to approach
4 him in a calm, measured way to reassure him, to
5 introduce themselves, to explain why they were there,
6 and to try and sit down with him to reassure him rather
7 than to be very authoritarian with him.
8 Q. I think in paragraph 6 of your statement you describe it
9 as something like, "Let's sit down and have a cup of tea
10 in this cafe"?
11 A. Yes, that is right. I think -- I felt at the time that
12 if this hadn't been an armed police squad, if it had
13 been an old-fashioned sort of police officer who had
14 arrived, who had been the first on the scene, or
15 a couple of officers, they would have been less forceful
16 and more inclined to try and have a chat with Mr Briggs
17 and the outcome could well have been different.
18 Q. Then in paragraph 8 of your statement you say:
19 "The jury criticised the restraint by the police
20 which ... [was] ... mostly in the prone position with
21 the application of inappropriate use of force. They
22 also criticised a failure to recognise Mr Briggs as
23 a medical emergency, inadequate assessments and
24 a failure to monitor him. These failures contributed to
25 his death."

1 A. That is correct. The ambulance service -- the ambulance
2 people were present, were witnessing what was going on,
3 but they did not get involved and they were criticised
4 because they said they hadn't been trained how to help
5 in these situations.
6 Q. This is -- sorry.
7 A. There was a lack of monitoring of a person who was by
8 then in a physically distressed state as a result of --
9 it's the combination of restraint and struggling against
10 restraint.
11 Q. Sorry, there was some coughing there and I didn't hear
12 your answer, you said there was a combination of
13 restraint and ...?
14 A. And struggling against restraint.
15 Q. Thank you. You gave evidence --
16 A. This might be --
17 Q. Sorry, I interrupted there. Please finish your answer.
18 A. This might be an opportunity to explain what happens in
19 these situations, where an individual who is being
20 restrained, especially if they are paranoid, ie have
21 a mental state in which they believe that they are being
22 persecuted or people wish to harm them, then when they
23 are restrained they will struggle against the restraint
24 because they believe that they are going to be harmed
25 even worse, and the struggle -- there is a vicious

1 circle of struggling and fear on the part of restrained
2 person, and the struggle provokes the restraining
3 officers to exert even more pressure.
4 So from the patient's point of view it is a life and
5 death struggle. From the restraining officers' point of
6 view it's a sign of lack of cooperation.
7 Q. Thank you. You gave evidence at the inquest in relation
8 to the death of Leon Briggs and that was --
9 A. Yes.
10 Q. That was in 2021?
11 A. That is correct.
12 Q. Thank you. I would like to move on now to your
13 involvement with the death of Mr Bayoh.
14 A. Yes.
15 Q. I am not asking you to remember exact dates but I will
16 read out some things that you have said in your
17 statement and you can hopefully confirm the general
18 dates. So you had a letter of -- you were instructed by
19 PIRC originally?
20 A. Yes.
21 Q. And they sent you a letter of instruction
22 in November 2015, is that correct?
23 A. That is correct.
24 Q. Had you had much involvement with them prior to
25 the November of that year?

1 A. With PIRC?
2 Q. With PIRC?
3 A. No, but I had done a couple of reports for the English
4 equivalent which was then called the Independent --
5 Q. IOPC?
6 A. -- even then it had a different name, the Independent
7 Police Complaints Commission.
8 Q. Right.
9 A. And I had --
10 Q. For people in the room, that letter of instruction is
11 COPFS 06007. We will see this is a letter dated
12 19 November 2015 and on page 2 we can see that PIRC
13 asked you to prepare an expert witness report on their
14 behalf. And they were interested --
15 A. Yes.
16 Q. -- in your views on the potential impact of the drugs
17 identified on the behaviour of Mr Bayoh.
18 A. Yes.
19 Q. And as that had been described by police and civilian
20 witnesses.
21 A. That is correct.
22 Q. Then they had also initially asked you about views on
23 behavioural science and the mindset of the officers as
24 a group but I think you latterly said that was not
25 within your area of expertise.

1 A. That is correct. I felt that that was more the domain
2 of the social psychologist.
3 Q. Thank you. You subsequently prepared a report for PIRC
4 which we have as COPFS 00130 and you sent that to them
5 on the following year, 18 January 2016.
6 A. That is correct.
7 Q. As part of preparing your report, did you consider
8 a number of documents and information that PIRC had sent
9 you?
10 A. Yes. And a video.
11 Q. Was that CCTV footage?
12 A. Yes. That must have been CCTV, showing Mr Bayoh mainly
13 running in the street. I didn't see him being
14 restrained in the video.
15 Q. We've seen CCTV images, I don't plan to play them today,
16 but we have seen some images of Mr Bayoh walking on
17 a journey towards Hayfield Road and actually in
18 Hayfield Road. Is that the images that you saw?
19 A. Yes, that is right. And the striking thing was that he
20 seemed to be wandering almost aimlessly, he seemed to be
21 disorientated. He took no care about his personal
22 safety in terms of risk of being knocked down by cars
23 and so on.
24 Q. I think --
25 A. But he did seem -- he seemed bewildered.

1 Q. I think in your report you mention seeing him near
2 a roundabout at Hayfield Road and he --
3 A. Yes.
4 Q. I think you use the word "confused"?
5 A. That is right.
6 Q. And you were also sent civilian witness statements and
7 police statements?
8 A. Yes.
9 Q. Medical reports and post mortem information as well, is
10 that right?
11 A. Yes.
12 Q. And you considered all of that before you prepared your
13 report for the PIRC?
14 A. Yes. I did.
15 Q. Thank you. As part of your report which I can see is --
16 you've summarised a lot of information that you were
17 sent and highlighted what you considered significant or
18 relevant for your purposes?
19 A. Yes.
20 Q. Thank you.
21 A. Yes.
22 Q. And you talk about the nature of -- we've heard
23 evidence, Dr Lipsedge, of the drugs which were found in
24 samples that were analysed as part of the assessment of
25 the pathology, and you've mentioned in your report the

1 impact of a drug called MDMA that we've heard is
2 commonly called ecstasy?
3 A. That is correct.
4 Q. Would you be able to give the Chair just a small summary
5 of the impact that drug has on a person's state of mind?
6 A. Well, normally ecstasy/MDMA is a stimulant, it's not
7 generally associated with severely adverse psychiatric
8 effects. There are some reports of it causing paranoia
9 but that's unusual. The more general impact in terms of
10 the way an individual who has taken ecstasy would relate
11 to other people is actually they may feel better
12 disposed than usual to other people. It is a drug that
13 is usually taken in nightclubs, and people take it
14 partly because it actually is thought to generate
15 a feeling of non-aggression and of friendliness rather
16 than paranoia.
17 Q. Thank you.
18 A. However, there are some reports, but this is rare, of it
19 having the opposite effect.
20 Q. I think on page 16 of your report you say:
21 "It's relatively rare but it can be associated with
22 acute paranoid psychosis."
23 A. Yes, and that is what I meant when I said that that is
24 a rare side-effect.
25 Q. That is towards the bottom of the page 16. Can you

1 explain to the Chair how someone would appear if they
2 are suffering from acute paranoid psychosis?
3 A. Yes. They would appear very frightened and suspicious,
4 and very difficult to engage and to reassure because
5 they believe that either specific people or people in
6 general or some external agency or a combination of
7 those are plotting to harm them.
8 So they may take defensive action or they --
9 an example might be as they come into a consulting room
10 they might unscrew the light fitting because they
11 believe that there is some electronic device which is
12 bugging them. So that sort of highly suspicious
13 behaviour. They might accuse people who they don't know
14 of wishing to harm them, plotting against them,
15 organising a conspiracy against them. It is a very
16 difficult state to deal with, but it is very important
17 to listen to a person who is in that frame of mind, not
18 necessarily to agree with them but to make sure that
19 they know they are being listened to --
20 Q. Can that help --
21 A. -- rather than being -- yes.
22 Q. What difference does listening make to a person in that
23 state of mind?
24 A. I think it shows the -- reassures the individual that
25 they are being taken seriously and that they are not

1 being dismissed out of hand. It is quite often possible
2 to establish some sort of rapport with people who are
3 paranoid because the paranoia might just be focused on
4 one particular area of suspicion and in all other
5 aspects the person may be functioning normally and have
6 otherwise normal beliefs.
7 So the doctor, nurse, ambulance people, and indeed
8 the police should try to work with the non-suspicious
9 aspect of a person's mental state if they possibly can.
10 It is not always possible.
11 Q. How does that exercise of building rapport and listening
12 help someone deal with a person who is in a paranoid
13 state of mind?
14 A. It is a question of showing the individual that you are
15 listening, that you are taking them seriously, that you
16 are prepared to consider what their belief is. It
17 doesn't mean you necessarily have to agree with them
18 that there's an awful conspiracy mobilised against them,
19 but hearing their version and -- rather than refusing to
20 listen is reassuring to the patient.
21 Q. From a psychiatric --
22 A. It allows you to establish --
23 Q. Sorry to interrupt again.
24 A. Yes, listening allows you to -- and possibly giving
25 feedback, so saying to the person who is unscrewing the

1 light fitting looking for a bug, saying, "I can see that
2 you're afraid that somebody is monitoring your movements
3 or your behaviour, your speech, and I can understand
4 that is the reason you are actually carrying
5 a screwdriver to unscrew the light fittings", and so on.
6 And then you would add, "Of course I understand that
7 must be very frightening for you", and then you would
8 try and reassure the individual by perhaps asking them
9 about other aspects of their life which might be
10 perfectly normal and you can engage in a conversation on
11 a neutral subject and try to defuse the fear and indeed
12 the terror --
13 Q. So are you --
14 A. -- that the person is experiencing.
15 Q. -- talking about an acknowledgement of the way the
16 person is feeling --
17 A. Yes.
18 Q. -- but not necessarily an agreement or an acceptance
19 that that is valid?
20 A. Yes. That is -- yes, Ms Grahame, you have put that very
21 well. Acknowledgement rather than agreement.
22 Q. And from your perspective, doctor, is there a time
23 constraint or limits to the time that can be taken to
24 build that rapport and engage with that person?
25 A. What I teach medical students is in a situation like

1 that you have to pretend that you've got unlimited time.
2 Of course you haven't got unlimited time but you have to
3 give the patient the impression that you are able to
4 listen to them and that you are not in a hurry.
5 My experience is that people feel, to use a local
6 term "disrespected" if you show that you're in a hurry
7 or if you've got a deadline. Now, of course for
8 professional reasons you might well be in a hurry but
9 you have to convey the feeling that you have unlimited
10 time to spend in discussion with the patient.
11 Q. It probably goes without saying that, if circumstances
12 change or the person becomes a danger to themselves or
13 others --
14 A. Yes.
15 Q. -- then that might be a reason to limit that time that
16 you are engaging with the person, presumably?
17 A. Of course. What I should have said right at the
18 beginning is if a person is armed with a gun or with
19 a knife or some other weapon, what I have been
20 describing is completely unrealistic and safety takes
21 top priority. But if during the dialogue the situation
22 changes and the patient tries to attack you or somebody
23 in the room, then you've got no alternative but to use
24 physical restraint.
25 Q. Thank you. Then moving on to another drug that you have

1 mentioned in your report, you mention Alpha-PVP.
2 A. Yes.
3 Q. We've heard that that is a synthetic cathinone.
4 A. Yes. Now, that is a very powerful stimulant. It's
5 a synthetic drug which has been manufactured since
6 probably round about 2000. And it's like a very, very
7 potent form of amphetamine. We know that amphetamine
8 has the potential to cause extreme paranoia fairly
9 quickly. That is to say within 20 minutes, 45 minutes.
10 It acts quickly. It doesn't do that to everybody but in
11 a person who happens to be susceptible then there can be
12 a paranoid reaction which can be extreme, and that is
13 what I think happened to Mr Bayoh.
14 Q. I think we've certainly heard evidence that he had
15 Alpha-PVP in his system. I think --
16 A. Yes.
17 Q. -- you say at the end of -- bottom of page 14 that the
18 effects of this can last for three to five hours?
19 A. Yes.
20 Q. Is that a sort of reasonable range, an estimate, or is
21 that ...?
22 A. No, that seems correct to me, and the onset, as I said,
23 is fairly rapid, it could be within 20-40 minutes.
24 Q. Thank you. If we look at page 15 you talk in your
25 report about some common adverse psychiatric and

1 neurological effects, and you mention -- if we can stop
2 there -- agitation, paranoia, hallucinations, seizures
3 the release of noradrenaline which causes rapid
4 heartbeat and raised blood pressure.
5 A. Yes.
6 Q. Can you help the Chair understand how someone having
7 taken this drug would appear and what their state of
8 mind would be?
9 A. The state of mind certainly in this case, and as
10 described in the literature on novel -- they are called
11 novel or new psychoactive drugs and this is a good
12 example, the street name was bath salts, the adverse
13 effect is -- the adverse psychiatric effect, as
14 I mentioned, is suspicion moving into paranoia, intense
15 fear that other people want to harm you.
16 Q. Right.
17 A. And in Mr Bayoh's case it is clear that there was
18 a progression from suspecting that -- his friends were
19 having a conversation about another person who wasn't
20 present, Mr Bayoh thought that they were talking about
21 him. And then the situation escalated, so that he began
22 to think that his friends were actually against him and
23 that culminated in what I thought was a very serious
24 attack indeed on his best friend, who felt -- his best
25 friend felt his own life was in danger given the

1 ferocity of the assault.
2 Q. So you mention on page 13 of your report that you've
3 considered the statements of his friends.
4 A. Yes.
5 Q. Who noticed, if I may summarise, a change in his normal
6 behaviour. He seemed to be --
7 A. Yes.
8 Q. -- acting out of character?
9 A. Yes.
10 Q. And I think one of the police officers who gave evidence
11 said he understood that Mr Bayoh had felt disrespected
12 in the home of a friend and had left quite suddenly.
13 A. Yes. That is absolutely ...
14 Q. And you've talked about the development of these adverse
15 psychiatric reactions. I think in your report you
16 mention the first sort of stage of psychosis. Can you
17 explain to the Chair how psychosis develops?
18 A. Well, I use the term "ideas of reference". That is
19 where a person suspects that either other people or,
20 for example, television are referring specifically to
21 that individual. Either giving them a special message
22 but very often saying something hostile and negative and
23 threatening. So this then evolves into, as in this
24 case, challenging his friend. He accused one of his
25 friends of being in the CID and he became increasingly

1 suspicious. And it was clear that he felt they wished
2 to harm him, which obviously wasn't the case.
3 Q. And then --
4 A. I think it is important --
5 Q. Sorry, I interrupted there.
6 A. It's important to mention that his friends reported
7 there had been similar but less severe episodes in the
8 past, and that wasn't altogether surprising because we
9 know that one can start with a relatively minor reaction
10 and then, as time goes on, with repeated usage of a drug
11 like this the brain becomes sensitised and the
12 individual becomes more vulnerable and more likely to
13 have a more extreme reaction.
14 Q. Then I think returning to page 15 you do talk about
15 psychiatric effects can include severe panic attacks,
16 extreme agitation, paranoia, hallucinations and violent
17 behaviour in connection with this drug?
18 A. That's correct, yes. That's right.
19 Q. In terms of psychosis would that be at the more extreme
20 level of behaviour? You've described how it starts off
21 as --
22 A. Yes.
23 Q. -- paranoia but ...?
24 A. Yes. Well, it starts off with paranoia but then
25 paranoia would be on a spectrum of mild to very severe,

1 and simply means -- in this context, it means
2 an unwarranted suspicion that people are against you,
3 hostile, wish to harm you.
4 Q. Thank you. Then finally you also mention the existence
5 of steroids in his system which were noted, we heard
6 evidence about that this week and you've talked on
7 page 14 of your report about there being a strong
8 temporal relationship between steroids and violent
9 outbursts or violence -- that is at the top of
10 page 14 -- even where people have no previous history of
11 violent behaviour.
12 A. Yes. I have to emphasise that we're talking about
13 so-called bodybuilding steroids as opposed to
14 therapeutic type of steroids.
15 Q. Of course. Sorry.
16 A. Now, these anabolic or bodybuilding steroids, there have
17 been quite a lot of reports of these bodybuilding drugs
18 causing aggressive behaviour. However, more recent
19 research suggests that the earlier papers tended to
20 overlook the possibility that the bodybuilder was taking
21 stimulant drugs at the same time. That is to say drugs
22 like amphetamine. And amphetamine in large doses can
23 cause violence, aggression, hostility, paranoia, and so
24 on, so the earlier reports didn't disentangle the
25 possibility that it wasn't just the steroids, the

1 bodybuilding steroids but it could have been other drugs
2 that were being taken at the same time, and which were
3 being commonly used by bodybuilders.
4 Q. I think --
5 A. So --
6 Q. If we look at your opinion in your report, the final
7 paragraph on page 9 you take the view that -- you took
8 the view that the steroids were unlikely to have
9 contributed significantly to the paranoid and violent
10 behaviour and it was better accounted for by the other
11 elements in his system.
12 A. Yes. Especially the Alpha-PVP.
13 Q. The Alpha-PVP particularly?
14 A. Yes.
15 Q. I would like to just go over your opinion with you, if
16 I may. It's page 18 of your report.
17 A. Yes.
18 Q. You talk about this being a retrospective psychiatric
19 diagnosis. Is this the part of your report where you
20 brought together all you had learned from the documents
21 and information you had been sent and your consideration
22 of the CCTV footage and then expressed your view to
23 PIRC?
24 A. That is correct.
25 Q. I think you talked about the rapid changes in Mr Bayoh's

1 mental state and behaviour from apparent normality were
2 consistent with psychostimulant intoxication?
3 A. That's correct.
4 Q. Can you explain to the Chair what psychostimulant
5 intoxication is?
6 A. Yes. Psychostimulants are drugs like amphetamine, like
7 cocaine, like the group of drugs called cathinones in
8 which they have a sort of exciting, excitatory effect on
9 the brain on the nervous system, and there is a release
10 of dopamine, which is the pleasure seeking component.
11 There's also a release of adrenaline and noradrenaline
12 which can raise -- very commonly raise the heart rate,
13 raise blood pressure, and cause strain on the heart to
14 make the heart vulnerable. And if a heart is deprived
15 of oxygen, which can happen during restraint, then there
16 is a risk of cardiac arrest due to a disturbance of the
17 rhythm of the heart.
18 Q. We've heard that Alpha-PVP of itself could result in
19 a fatality?
20 A. Yes.
21 Q. Can I be clear, is psychostimulant intoxication
22 a descriptive term or is it a recognised psychiatric
23 disorder?
24 A. Oh, it's a recognised psychiatric disorder, and it has
25 been in the diagnostic manuals, that is

1 the International Classification of Diseases and then
2 the American system which is the Diagnostic and
3 Statistical Manual. It has been in successive editions
4 of those two manuals for several editions over a couple
5 of generations I guess.
6 Q. Thank you.
7 A. So it's a well-recognised category.
8 Q. Thank you. Then you describe in your report:
9 "His condition evolved rapidly in a pattern that is
10 well-recognised in descriptions of drug-induced
11 intoxication."
12 Is that the same more general --
13 A. That is the same. Yes. Yes. That is correct.
14 Q. You've talked about the psychosis caused by these
15 stimulant drugs:
16 "... evolving from a period of increasing
17 restlessness, suspiciousness and ideas of reference~..."
18 Which you have mentioned earlier, and:
19 "... the patient misinterprets every day events or
20 conversations in a delusional fashion, believing that
21 people are plotting against him or are about to attack
22 him. The patient may act on these beliefs with
23 extremely violent behaviour."
24 A. Yes. Yes. Exactly.
25 Q. Then I think in your opinion you say:

1 "Although some pathologists and toxicologists use
2 the term 'excited delirium' to describe this clinical
3 picture, most British psychiatrists prefer to use the
4 term 'psychostimulant psychosis' when there is
5 toxicological evidence of the use of~..."
6 And you list a number of drugs including cathinones.
7 A. That is correct.
8 Q. We've heard evidence to the Inquiry that MDMA and
9 Alpha-PVP are indeed cathinones.
10 A. I'm not sure that --
11 Q. Actually --
12 A. -- ecstasy is a cathinone.
13 Q. Sorry, I am confused. It's Alpha-PVP that is
14 a cathinone?
15 A. It is a cathinone, yes.
16 Q. Sorry that was my mistake. Then you talk about the
17 previous use and sensitisation. Was this the examples
18 that you obtained from the friends who had spoken about
19 maybe previous experiences he had had?
20 A. Yes, exactly.
21 Q. Can you explain to us what sensitisation is?
22 A. The way it's the -- it's the opposite of habituation so
23 if I can use an analogy with alcohol, over the years
24 a person may become tolerant to the intoxicating effects
25 of alcohol, so that they are able to drink increasing

1 amounts with less undesirable effects.
2 Now, sensitisation is the opposite to that, so with
3 successive exposure to the -- to Alpha-PVP the brain
4 reacts increasingly in a negative way with increasing
5 risk of the intoxication that I referred to, and an
6 increasing risk of paranoia, suspicion and violence.
7 Q. Thank you. I am conscious of the time but I have only
8 one last question in relation to your report, if I may
9 ask that.
10 A. Yes.
11 Q. You had said when you prepared this report that in
12 addition to the drugs, that it appeared, from the
13 information you were sent, that he had drunk
14 a significant amount of alcohol shortly before he began
15 to express paranoid ideas. And you commented on the
16 connection with alcohol.
17 I understood you were subsequently advised that that
18 was not -- although eyewitnesses had spoken of him
19 drinking alcohol, it didn't prove to be the case from
20 the results obtained in terms of the pathologists'
21 investigations. But did that make any difference at all
22 to your overall view about the psychostimulant
23 intoxication?
24 A. No, I felt that -- I accepted the account from his
25 friends that he had drunk alcohol and my view was if

1 that was the case, and I had no reason to doubt that it
2 was the case until I saw the toxicologist's report, if
3 that was the case, it would just make the reaction to
4 Alpha-PVP worse.
5 Q. Thank you.
6 A. That would exaggerate the negative effects.
7 MS GRAHAME: Thank you very much.
8 LORD BRACADALE: Dr Lipsedge, we will take a 15-minute break
9 now and we will then carry on until lunchtime.
10 A. Yes, sir.
11 LORD BRACADALE: Thank you.
12 (11.47 am)
13 (A short break)
14 (12.06 pm)
15 LORD BRACADALE: Yes, Ms Grahame.
16 MS GRAHAME: Thank you very much.
17 Can you still hear me, Dr Lipsedge? Dr Lipsedge can
18 you hear me? (Pause).
19 Dr Lipsedge, can you see me? No.
20 We will maybe give it a moment.
21 LORD BRACADALE: We will just give it a moment to see if it
22 is resolved. (Pause).
23 Dr Lipsedge? Are you hearing me now, Dr Lipsedge?
24 (Pause).
25 MS GRAHAME: I'm not sure he can hear or see me.

1 LORD BRACADALE: I think that is right. We will rise again
2 briefly and see if we can resolve it.
3 (12.08 pm)
4 (A short break)
5
6 (12.13 pm)
7 LORD BRACADALE: Dr Lipsedge, I think we are back with you
8 again. Can you hear me?
9 A. Yes. I can hear you.
10 LORD BRACADALE: Ms Grahame.
11 MS GRAHAME: Thank you. Hello Dr Lipsedge, are you able to
12 hear me?
13 A. Yes, I can hear you clearly.
14 Q. Thank you. I was going to move on, you've mentioned two
15 articles that you wrote, and I would like to look at
16 both of them. Can we look first of all at the 2015
17 article that you mentioned. So that is by you alone
18 called, "Excited delirium: A psychiatric review". It
19 was published in the Medicine, Science and the Law
20 publication on -- first published on 8 June 2015. So
21 just over a month after Mr Bayoh's death.
22 A. Yes.
23 Q. The Chair will be able to read this article in detail at
24 a later date but there's one or two things I would like
25 to ask you about, if I may. I think you have already

1 said that this was an article in which you mentioned the
2 term excited delirium being used:
3 "... to explain sudden and unexpected
4 restraint-related deaths."
5 Was this the first mention, publication in the UK or
6 had it been mentioned in the UK prior to that?
7 A. As far as I know this was the first -- this was the
8 first comprehensive review published in this country.
9 Q. Right. We will come on to that again but I see on
10 page 1, if we look further down on our copy, I can see
11 that you have raised that:
12 "There has been an important divergence of
13 understanding of the term 'delirium'~..."
14 And I think you touched on that earlier this morning
15 and you mentioned the development of that divergence:
16 "... over the past 30 years or so since Wetli and
17 Fishbain used the term [excited delirium] specifically
18 to explain deaths during or after restraint in American
19 recreational cocaine users."
20 Was that when the term began to differ --
21 A. Yes.
22 Q. -- in relation to delirium? Can you begin by explaining
23 what delirium is from a psychiatric perspective?
24 A. Yes. Delirium is a term that is used to describe
25 a state which is often accompanied by a high temperature

1 in which a person is confused, agitated, disorientated,
2 fearful. Generally you come across it in hospital
3 patients, often elderly people or post-operatively. It
4 is pretty common and only lasts a day or two in
5 otherwise relatively fit people.
6 So it's a condition that you'd see in a hospital,
7 you might see it in homes for terminally ill people, but
8 generally it would be in an acute hospital setting.
9 Either post-operatively or as a feature of, say, kidney
10 failure, liver failure, sometimes cardiac failures,
11 sometimes respiratory failure, so it's -- or post-head
12 injury or during an infection, acute infection of the
13 brain.
14 So it's very well-recognised within medicine, with
15 the features that I have already mentioned: confusion,
16 agitation, disorientation. Another common form would be
17 what is called delirium tremens which occurs during
18 acute withdrawal from alcohol. That would come under
19 the same heading.
20 Q. Thank you. On page 2 of this report in the right-hand
21 column towards the latter half of that page, I see that
22 you say:
23 "For psychiatrists, delirium, by definition, is the
24 neuropsychiatric manifestation of either intoxication
25 by, or withdrawal from, a psychoactive substance, or of

1 one or more underlying serious and potentially fatal
2 medical conditions which might be infective,
3 inflammatory, metabolic, vascular, neoplastic or
4 traumatic."
5 And you also say:
6 "Some symptoms of delirium overlap with the symptoms
7 of primary psychiatric disorders."
8 And in the last paragraph you say:
9 "From a psychiatric perspective, if a patient dies
10 during a bout of delirium, there will be autopsy
11 evidence to confirm the underlying organic cause
12 (for example septicaemia). Thus, the cause of the
13 patient's death is not their psychiatric disorder or
14 their agitated behaviour, but a grave underlying medical
15 condition, which will be revealed at autopsy."
16 We move on to the next page:
17 "In the absence of an underlying physical cause for
18 an acute behavioural disturbance, the use of the term
19 'delirium' in this way is self-contradictory."
20 A. Yes.
21 Q. So it seems that you -- as a psychiatrist, am I correct
22 in saying you understand delirium to have a sort of
23 medical -- to be a medical condition with medical or
24 physical signs that may be available and observable at
25 a post mortem?

1 A. Absolutely.
2 Q. To that extent is it different then from the term
3 "excited delirium"?
4 A. Yes. Because in excited delirium -- by definition
5 excited delirium, as the term was being developed in
6 the United States, there was no autopsy evidence of
7 a physical or an organic cause for the person's death.
8 Q. So the Chair should not be confused by the reference to
9 the term "delirium"? They are two separate things
10 altogether?
11 A. They are separate when it comes to describing a cause of
12 death. With delirium physicians, psychiatrists, we
13 would expect, if the patient dies, that a pathologist at
14 autopsy would find the cause for the delirium and the
15 cause of death. So for example septicaemia.
16 Q. Thank you.
17 A. For example meningitis. And my quarrel with the use of
18 the term "delirium" in the context of the American term
19 "excited delirium" was there was no evidence of
20 an organic cause for either the delirium or for the
21 death.
22 Q. Thank you. Then on page 3 of your report there's
23 a section entitled, "Acute behavioural disturbance and
24 the risk of fatal outcome", and you say:
25 "In general, severely disturbed behaviour which

1 requires restraint might have: (a) a medical cause, (b)
2 a primary psychiatric aetiology, or (c) be due to
3 recreational drug use~...
4 "Medical causes include those numerous organic
5 conditions which cause delirium as defined in both
6 DSM-IV and DSM-5 as well as in ICD-10 and in standard
7 medical and psychiatric textbooks. There is an obvious
8 mortality associated with the underlying organic
9 condition. Neuroleptic malignant syndrome would be
10 included in this section. Most antipsychotic drugs can
11 often be associated with sudden, unexplained and
12 unexpected deaths."
13 A. Yes.
14 Q. Again, is it correct to say then that delirium is
15 a recognised psychiatric condition that appears in
16 DSM-IV and 5 and ICD -- you said 10 in this report and
17 it's now ICD-11, it's a new version now. Is that
18 recognised within those classifications?
19 A. Absolutely.
20 Q. My understanding is that DSM-IV was published in 1994
21 and 5 was published in 2013. And ICD-10 was published
22 in 1992 and 11 was published in January of last year,
23 2022?
24 A. That is correct. Yes.
25 Q. ICD-10 is a globally used diagnostic tool which is used

1 for clinical purposes and it is maintained by the World
2 Health Organisation; is that correct?
3 A. That is correct. Yes.
4 Q. And DSM, the Diagnostic Statistical Manual is
5 a diagnostic tool published by the American Psychiatric
6 Association and is a standard classification of mental
7 disorders used by mental health professionals in the US?
8 A. That is correct.
9 Q. Thank you. They are both well known in the Scottish
10 courts also, Dr Lipsedge.
11 A. Yes. Yes.
12 Q. Then you go on in this report to make clear on page 4
13 that:
14 "[Excited delirium] does not appear as a separate
15 diagnostic category~..."
16 If we can just move down that page, please, so:
17 "ED does not appear as a separate diagnostic
18 category in DSM-IV or DSM-5, or in ICD-10. The term
19 'delirium' in the American forensic pathology literature
20 is not used in the restrictive DSM or ICD sense of acute
21 behaviour disorder attributed to an underlying organic
22 condition."
23 So in this section of your 2015 article is it clear
24 that as a concept excited delirium does not appear in
25 either of the classification tools, the DSM or ICD-10

1 which are used around the world?
2 A. If we look at ICD-10 which covers -- or ICD in general,
3 the publication by the World Health Organisation, they
4 cover all recognised diseases, and they would include
5 delirium but in the sense that we've discussed just now,
6 ie where delirium is an agitated confused state of
7 a patient who has an underlying medical cause for their
8 agitation and disorientation. So it's used in a medical
9 context.
10 Q. Excited delirium does not appear in either of those
11 publications as a separate diagnostic category?
12 A. Well, delirium appears in ICD, and delirium is described
13 as either stuporose or its opposite, which is agitated
14 or excited. But the context, the explanation, is very
15 important. It's always attached to the presence of
16 an underlying physical cause.
17 Q. Thank you.
18 A. And the way excited delirium was being used in
19 the United States was by definition the absence of
20 an underlying physical cause.
21 Q. Thank you. Then in your conclusions in 2015 which we
22 can see at the bottom of page 6 you say:
23 "At present, the term ED might imply that an acute
24 behavioural disturbance can, in and of itself, be the
25 main cause of death, even in the absence of

1 an underlying demonstrable organic cause. However, it
2 is debatable whether ED as defined clinically and
3 pathologically can be conclusively regarded as the main
4 cause of death as opposed to the cardiotoxic effects of
5 psychostimulants and/or aspects of the restraint
6 procedure itself."
7 A. Yes.
8 Q. Thank you. That was your article from 2015, at that
9 time?
10 A. Yes.
11 Q. And then you've explained to us that you then wrote
12 an article which was published in 2022 alongside
13 Terry McGuinness.
14 A. Yes.
15 Q. If we --
16 A. Terry McGuinness is the senior author. He is
17 a barrister with an interest in inquests and the
18 coronial process, so he was the senior author and we
19 have been colleagues and friends for some years, because
20 of our shared interest in the question of
21 excited delirium.
22 Q. Is that how you came to write an article together?
23 A. Yes. Yes.
24 Q. We will have that on the screen here in the room,
25 WIT 00018 and you provided a copy of this article to the

1 Inquiry which the Chair will be able to read in detail.
2 But this was published last year and is entitled
3 "'Excited delirium', acute behavioural disturbance,
4 death and diagnosis".
5 A. Yes.
6 Q. Essentially I think earlier you explained that this goes
7 through the history of the development of
8 excited delirium, as it has become known; is that
9 correct?
10 A. Yes. That is correct.
11 Q. From the abstract on page 1 do we see that you talk
12 about the situation in the 1980s, and the traditional
13 Hippocratic term and how:
14 "... excited delirium was transplanted from the
15 bedsides of febrile, agitated and disorientated patients
16 to the streets of Miami."
17 And it related to the difficulties that they
18 experienced in America with cocaine use.
19 A. That is right. And in particular the phenomena of
20 people who had taken a very powerful form of cocaine,
21 crack cocaine, who died -- who behaved violently in
22 public places, who were restrained, who died, and the
23 important thing is in terms of diagnosis or cause of
24 death the serum levels, the blood levels of cocaine were
25 only one-tenth of the lethal dose of cocaine. So it was

1 difficult to account for the deaths in terms of cocaine
2 itself.
3 Q. You say in the abstract:
4 "Over the course of the next few decades
5 'excited delirium' might be applied to virtually any
6 highly agitated person behaving violently in a public
7 place and who subsequently died in custody while being
8 restrained or shortly afterwards. Expert witnesses,
9 mainly forensic pathologists, testified that
10 the deceased's death was probably inevitable given the
11 perilous nature of excited delirium, even though this
12 diagnostic entity lacked any consistent
13 neuropathological basis and depended entirely on
14 observed behaviour."
15 Was that the forensic pathologists in the US who
16 were --
17 A. Oh, yes.
18 Q. -- giving evidence?
19 A. That is right. In the United States a book on
20 excited delirium by a husband and wife team, the
21 Di Maios, in a book that was actually dedicated to law
22 enforcement officers who had been accused of causing the
23 death of restrained individuals. This became
24 a handbook, was distributed as free copies to police
25 forces where there was a death in custody and this sort

1 of -- this became a widely quoted text to account for
2 deaths in custody. So rather than restraint as a cause
3 of death, excited delirium was invoked.
4 Q. Who were the Di Maios? What job did they do?
5 A. Vincent Di Maio in Texas, I think he was a forensic
6 pathologist and his wife was a forensic nurse. There is
7 just one edition of the book that came out in about
8 2006.
9 Q. The use of that book was in relation to pathologists not
10 psychiatrists?
11 A. Absolutely. It was used by pathologists and by lawyers
12 in cases where there were complaints about restraint,
13 about deaths in custody.
14 Q. As part of the introduction of this article from 2022
15 you talk about a recent example, a well known example,
16 of where this has arisen in the trial of officer
17 Derek Chauvin for the murder of George Floyd?
18 A. Yes.
19 Q. We know he was convicted of murder in June 2021.
20 A. Yes.
21 Q. Can you help the Chair understand where excited delirium
22 as a concept had got to by the stage of the George Floyd
23 death?
24 A. Yes. Well, I think it is generally agreed that
25 George Floyd died from what might be called suffocation,

1 using a lay term, and a pathologist giving evidence at
2 the trial of Chauvin suggested that he had died of
3 excited delirium rather than from restraint.
4 Q. That was obviously rejected by the jury in that trial?
5 A. Yes, yes.
6 Q. Since that trial have attitudes changed in America to
7 the concept of excited delirium?
8 A. Yes. Yes. Well, the American Medical Association has
9 never recognised the concept. The American College of
10 Emergency Physicians, which had recognised it, has
11 reviewed the concept and has changed the name. There
12 have been other changes, in this country for example the
13 Royal College of Pathologists has banned the use of the
14 term "excited delirium". And the Royal College of
15 Emergency Physicians in its 2016 handbook had within the
16 title, "Acute behavioural disturbance/excited delirium",
17 and in the 2022 edition they have dropped the initials
18 for excited delirium. So overall there has been a move
19 away from it, and the --
20 Q. (Inaudible - overspeaking) actually the Royal College of
21 Psychiatrists in the UK?
22 A. Well, it has never recognised it in the first place.
23 Most importantly I think the Angiolini report said the
24 term should not be used, and following the death of
25 Roger Sylvester I think the Metropolitan Police or

1 a coroner around about that time recommended that
2 the term should not be used. I think that was in 2004.
3 Q. We're going to come to those things because you happily
4 mention a number of these in your article from last
5 year. Can we maybe -- looking for me at page 2, I see
6 that you say in paragraph 3 towards the bottom:
7 "Whilst the US National Association of Medical
8 Examiners and the American College of Emergency
9 Physicians consider excited delirium to be a mental
10 health condition, it is not recognised by the American
11 Medical Association, the American Psychiatric
12 Association or the World Health Organisation and nor is
13 it to be found in DSM."
14 A. Yes.
15 Q. You go on to explain:
16 "A diagnostic entity requires a standardised
17 definition, a specific diagnostic test, and a unique
18 pathophysiological mechanism with a consistent morbid
19 anatomical basis or a specific aetiology. By contrast
20 excited delirium has been defined mainly on the basis of
21 subjective descriptions of severely agitated behaviour."
22 A. Yes. Yes. That is really what I was referring to when
23 I said there was no objective laboratory or post mortem
24 or other objective evidence to support a diagnosis of
25 excited delirium.

1 Q. So is excited delirium more of a description of
2 different behaviours?
3 A. Yes. Yes, indeed.
4 Q. Is there anywhere a standard list of the behaviours that
5 could be -- a list that could be ticked or classified as
6 coming within --
7 A. Well, the -- indeed. Well, the American College of
8 Emergency Physicians produced what they called
9 a White Paper which was an attempt to provide
10 a definition of what they called excited delirium
11 syndrome, and that provided a checklist which was issued
12 to police forces really to alert them to the possibility
13 that an individual who was apprehended might be in
14 a risky physiological state and indeed might be at risk
15 of dying from -- they actually said one or more of this
16 cluster of behaviours. So there were roughly, from
17 memory, something like ten possible features, but in
18 practice the presence of just one of them was sufficient
19 to provide a diagnosis of excited delirium syndrome.
20 Q. In your article you also mention the situation with
21 British psychiatrists and we've briefly talked about
22 the Royal College of Psychiatrists and they've recently
23 issued a position statement in September of last year
24 about acute behavioural disturbance and
25 excited delirium.

1 A. Yes. I was on the committee that discussed this over
2 several months and produced this paper. First of all,
3 we rejected out of hand excited delirium for the reasons
4 that we've been discussing, and that are really
5 enumerated in the two papers that I have written, the
6 second one with Terry McGuinness.
7 The more controversial term is acute behavioural
8 disturbance, and that has now -- that term has been
9 adopted by -- mainly by emergency physicians and by
10 the emergency services to describe what used to be
11 called excited delirium. Now, from the college point of
12 view we feel that is too restrictive an interpretation
13 of the term acute behavioural disturbance. This may
14 sound a bit semantic or pedantic but what we especially
15 wanted to draw professionals' attention to, and the
16 emergency services' attention to, was that there is
17 a spectrum of disorders with a wide -- of -- sorry, of
18 behavioural presentations, with a wide range of
19 underlying causes, and at the most severe end is what
20 the emergency physicians will see, where a person might
21 be in a very severe physiologically disturbed state, and
22 those are people who quite rightly should be in the A&E
23 departments of hospitals.
24 What has been overlooked we felt was at the other
25 end of the spectrum, if you like the non-physiological

1 end of the spectrum, is people who are very upset or
2 agitated or distressed by -- generally by bad news or
3 an unpleasant personal or domestic or family or
4 professional situation, who might be seen in public, who
5 are distressed, crying, weeping, possibly falling to the
6 ground, et cetera, who are not physiologically
7 disturbed, who do not need to be taken to A&E but who do
8 need an approach which is based on what we were talking
9 about earlier when we talked about de-escalation. What
10 they need is a friendly person to listen to them, to
11 reassure them, and to sort of -- yes, to provide
12 reassurance, and you don't actually need generally
13 a professional to help. Neighbours might help in that
14 situation, or a general practitioner might help. It is
15 not an extreme physical emergency such as the emergency
16 physicians see at hospital.
17 That is really one of the most important messages
18 from our report, was to draw attention to this spectrum
19 of presentations which the term acute behavioural
20 disturbance will cover.
21 Q. I will come back to that in relation to -- when we get
22 to the end of your article and explore that further. At
23 the moment can I just touch on your involvement with the
24 Royal College of Psychiatrists and you've explained that
25 you were on the working group that contributed to the

1 preparation of the position statement in September of
2 last year.
3 A. Yes.
4 Q. That is WIT 00021, if we can -- there's a couple of
5 things I would like to ask you about in this, obviously
6 the Chair can read the detailed statement in due course.
7 On pages 3 to 5 do we see an executive summary that was
8 prepared?
9 A. Yes.
10 Q. It talks about:
11 "The terms 'acute behavioural disturbance' ('ABD')
12 and 'excited delirium' ('ExD') have been used to
13 describe a situation in which a person is extremely
14 agitated and distressed, usually in a public place, and
15 in such a state of agitation that they may be at risk of
16 a potentially fatal physical health emergency. While
17 physical restraint must always be seen as the last
18 resort, it is thought to significantly increase the
19 likelihood of poor outcomes in this group of people."
20 What was understood by "poor outcomes"?
21 A. Risk of death. So it's recognising that sometimes
22 severely agitated people might need restraint, because
23 of violence, but the restraint itself increases the risk
24 of what -- the term you have referred to, poor outcome,
25 which means a risk of death.

1 Q. And it goes on to say:
2 "It has been argued that 'ExD' should be understood
3 as a distinct syndrome with a high likelihood of a fatal
4 outcome without medical intervention."
5 It describes:
6 "... a clear move in the UK towards 'ABD' as
7 a broader umbrella term for a patient presentation of
8 severe agitation, distress and signs of physiological
9 deterioration of unknown cause."
10 But it notes that:
11 "Neither term [ABD or excited delirium] is
12 recognised in ... (DSM-5) or ... (ICD-11)."
13 A. That is right.
14 Q. They go on to talk about the lack of validated criteria
15 to assess whether someone experiencing ABD for example.
16 So there is a lack of criteria even if you use the term
17 ABD?
18 A. That is correct.
19 Q. And:
20 "The current management guidelines may apply to
21 a significant number of people, including those
22 experiencing a mental health crisis."
23 And they talk about excited delirium having been
24 controversial:
25 "... when used in a way that minimises the role of

1 restraint in understanding why someone has died
2 following the use of force by police or health services,
3 particularly those from ethnic minority backgrounds.
4 The disproportionate use of force against people of
5 colour is well documented across health and criminal
6 justice in the UK."
7 Can you explain a little bit more about those
8 comments that were put in the position statement?
9 A. Yes. There is a chapter that deals with discrimination
10 on the basis of skin colour. Both -- certainly within
11 the mental health services and by -- when it comes to
12 restraint in public places, so the evidence for this was
13 accumulated by Sir Simon Wessely, past president of the
14 Royal College of Psychiatrists, in his review of the
15 Mental Health Act, and he found, for example, that there
16 is a highly disproportionate use of a section of the
17 Mental Health Act, this is the English Mental
18 Health Act, section 136, which allows the police to
19 detain a person who they perceive in a public place who
20 they deem to be suffering from some sort of mental
21 disorder and take them to what used to be called, or is
22 still called "a place of safety", which was originally
23 either a police station or an A&E department. Now
24 a police station would not be regarded as a place of
25 safety, and so an A&E department is the appropriate

1 place.

2 So there's an excessive use of section 136. When it

3 comes to the mental health service itself, black people

4 were more likely to be restrained while they were in the

5 hospital, more likely to be put into seclusion, more

6 likely to have lengthy admissions in secure units, more

7 likely to be involved in the criminal justice system as

8 well as the mental health system and less likely to have

9 extended psychological help once they were back in the

10 community.

11 So there's a general view that people of colour fare

12 badly within the mental health services in England, and

13 also seem to be discriminated against by the police.

14 Q. Thank you. Then the Royal College were calling for the

15 need for a robust consensus about how to understand,

16 define and respond to this issue and to make sure front

17 line services were supporting and providing the best

18 standard of care whilst ensuring appropriate scrutiny

19 and accountability in the event of a death. And --

20 A. Yes.

21 Q. -- that seemed to be their desire.

22 A. Yes.

23 Q. It says that there was extensive consultation by the

24 Royal College with stakeholders, including the police,

25 is that correct?

1 A. That is absolutely correct. Within the definition of
2 so-called excited delirium there were two terms that
3 were regarded, and are regarded, as racialised. One is
4 the use of the term "superhuman strength" as
5 a characteristic of excited delirium or acute
6 behavioural disturbance, superhuman strength, and the
7 other is "impervious to pain". In consultation with the
8 community and other stakeholders it was felt that those
9 two terms really resonated with the institution of
10 slavery. That is to say, severe measures to control
11 slaves were often justified by the use of the terms,
12 "oh, they don't feel pain in the way white people do",
13 or, "we have to control them with chains because they
14 have superhuman strength", and those two expressions
15 appear repeatedly in the definition of excited delirium,
16 and indeed of acute behavioural disturbance. And we
17 have felt -- we concluded that this was extremely
18 historically insensitive and -- not just historically
19 but part of racial stereotypes nowadays.
20 Q. So did the Royal College recognise that racially
21 stereotypical language was part of the definitions of
22 excited delirium?
23 A. Yes. Definitely.
24 Q. Was it also connected to ABD?
25 A. Yes. Because both of those terms, the imperviousness to

1 pain and the superhuman strength, are used in
2 descriptions of ABD by, for example, the Royal College
3 of Emergency Physicians --
4 Q. That is the American --
5 A. -- as recently as their 2022 edition.
6 Q. That is the American association?
7 A. No, sorry, the Royal College of Emergency Physicians.
8 Q. Sorry. Thank you. Then I think on page 4 of this
9 position statement the Royal College appears to
10 acknowledge the need for practical guidance for front
11 line staff who are being asked to respond to incredibly
12 challenging situations. Was there a recognition by the
13 Royal College that these are challenging situations that
14 staff have to deal with?
15 A. Absolutely, and ideally there should be arrangements in
16 which, if the emergency services are called to a person
17 who is described as suffering from acute behavioural
18 disturbance, in other words, a person who is very
19 agitated in a public place, then mental health trained
20 personnel should attend at the same time to help to
21 understand what is going on and very often I think take
22 over from ambulance and police.
23 Q. Were the Royal College also hoping that they can
24 encourage organisations to work together and to achieve
25 a consensus in relation to these ...?

1 A. Absolutely. To my mind, the important consensus
2 regarding the definition of ABD is to recognise milder
3 forms of the condition that do not require emergency
4 hospital treatment, but that do require the sort of
5 support that I have mentioned a couple of times.
6 Q. Then on page 5 of this document the Royal College, still
7 within the executive summary, talk about:
8 "... red flag approach to identifying physical
9 health emergencies in an agitated person and that would
10 help move away from diagnostic criteria based on
11 controversial literature on excited delirium."
12 And they wouldn't need to resort to what is called
13 a binary concept of ABD, and they criticise the current
14 definitions of ABD as:
15 "... too entangled with contested definitions of
16 excited delirium."
17 And they say excited delirium should never be used:
18 "Subjective and potentially racialised diagnostic
19 criteria should be removed."
20 So it appears that the Royal College were concerned
21 about the use of either excited delirium or ABD because
22 of the racialised diagnostic criteria?
23 A. Yes. Those were the "superhuman strength" and the lack
24 of sensitivity to pain, "impervious to pain". The
25 College -- you mention red flags, the red flags,

1 ie a warning of the possibility of a truly medical as
2 opposed to a psychological emergency or an emotional
3 emergency, the red flags would be -- top of the list
4 would be a high temperature; that is serious warning
5 sign for physiological deterioration. Another would be
6 non-stop physical activity; ceaseless physical activity.
7 Q. I am conscious of the time, Dr Lipsedge, but I only have
8 two other questions to ask you about this document
9 and I wonder if we could just finish those now. One
10 relates to what is page 8, the names of the people on
11 the working group. I see your name. I also see the
12 name of a Dr Derek Tracy and a Professor Keith Rix, and
13 I wonder if you could tell us who they are?
14 A. Yes. Dr Tracy is a very senior psychiatrist who wrote
15 a very important paper in a journal called Advances in
16 Psychiatric Treatment. He wrote it with Dr Stevenson,
17 who is an emergency physician in Glasgow, and they
18 wanted to draw psychiatrists' attention to what I would
19 call the extreme physiological distress end of ABD, and
20 they described in language that psychiatrists will
21 understand the physiological disturbances that put the
22 patient at risk ultimately of cardiac arrest.
23 Q. I am hoping to come to that this afternoon.
24 A. Right. Derek Tracy has also written a very important
25 work on novel psychoactive drugs, and Keith Rix is

1 a very well known medico-legal authority who has written
2 a great deal, especially on how to write medico-legal
3 reports but he's also got a long-standing interest in
4 this subject of excited delirium, and I have had lots of
5 discussions with him about this and he regards ABD as an
6 umbrella term, which is a useful context, and he wants
7 to emphasise there can be multiple causes, and he
8 emphasises that there's a spectrum ranging from the
9 emotional upset to the physiologically distressed.
10 Q. Thank you. Then the last thing I wanted to ask you
11 about this document is in relation to the annex which is
12 at the rear. It begins on page 37, and it's a table
13 that is a list of police contact-related deaths where
14 either ABD or excited delirium have been referenced as
15 part of IOPC investigations and/or inquests since 2005.
16 If we could look at page 40 of that table, people here
17 can see that. We see that on 3 May 2015 the
18 Royal College took account of Sheku Bayoh's death and
19 it's indicated they were aware that the Public Inquiry
20 was ongoing, and it also says that:
21 "Police Federation lawyer has suggested a link with
22 ABD."
23 And the source is given as Scottish Government 2020.
24 I just wondered if you know anything else about that
25 summary? "Police Federation lawyer suggested link with

1 ABD".

2 A. No, I don't.

3 Q. We may be able to look into that.

4 A. I think since you mention the Federation, just very,

5 very briefly because I know time is running out, I told

6 the Inquiry about my -- the reports I've done on deaths

7 in custody over the years, but I am an Honourary Fellow

8 of the Faculty of Occupational Medicine and that means

9 that over the years I have done a great deal of work

10 with public bodies, public employers, and indeed with

11 the British Transport Police, with the

12 Metropolitan Police, with Wiltshire police, with Surrey

13 police, dealing with issues of fitness for work, early

14 retirement and so on. But in addition, since you

15 mention the Federation, at the request of the Federation

16 and through their lawyers, I have done many, many

17 reports on personal injury sustained by police officers

18 in the course of their duty, especially officers

19 suffering from post traumatic stress disorder and other

20 psychiatric injuries caused during the course of their

21 work. I just wanted to emphasise that to counterbalance

22 your awareness of the fact that I have dealt over the

23 years with deaths in custody.

24 MS GRAHAME: Thank you very much, Dr Lipsedge.

25 LORD BRACADALE: Dr Lipsedge, we will stop there for lunch.

1 Our usual timetable in the afternoon is that we sit
2 between 2.00 pm and 3.00 pm, take a 15-minute break and
3 then sit between 3.15 pm and 4.15 pm. So if you are
4 comfortable with that, we will aim to do that this
5 afternoon.
6 A. Yes, sir. Thank you.
7 LORD BRACADALE: Thank you.
8 (1.05 pm)
9 (The short adjournment)
10 (2.00 pm)
11 LORD BRACADALE: Ms Grahame.
12 MS GRAHAME: Thank you. Dr Lipsedge, again can you hear me?
13 A. I can hear you Ms Grahame.
14 Q. Thank you. I am going back to your 2022 article, and
15 I think for those of us in the room we will see at the
16 very bottom of page 4 of the article that you make
17 mention of something, and I think you mentioned this
18 earlier in your evidence:
19 "In the United Kingdom, as early as 2004
20 a Metropolitan Police review recognised that the term
21 'excited delirium' ought to be removed from its
22 documentation following a coroner's warning that its use
23 'encourages failure to recognise the multifactorial
24 pathophysiology of deaths following restraint'~..."
25 That was a quote from the Metropolitan

1 Police Service in 2004. Is that the thing you mentioned
2 earlier in evidence?
3 A. Yes, I think it is. That followed the death in custody
4 of Roger Sylvester.
5 Q. And so as early as 2004 the Metropolitan Police Service
6 were acknowledging --
7 A. Yes.
8 Q. -- the issue. Right.
9 A. Yes.
10 Q. Then moving on to page 5, I see in your article that you
11 mention the Braidwood Inquiries, and --
12 A. Yes.
13 Q. -- this was a death in October 2007 involving the Royal
14 Canadian Mounted Police and a death at Vancouver
15 International Airport, and you describe this at the end
16 of that first paragraph there:
17 "These enquiries, conducted in 2009, 2010,
18 represented a major turning point in the
19 excited delirium story."
20 Could you help the Chair understand what this major
21 turning point was?
22 A. Essentially this is to do with an Inquiry into the death
23 of a Polish visitor to Vancouver who arrived in the
24 airport and he was rather confused and disorientated,
25 didn't speak English, and couldn't see his family who

1 were meant to be there to welcome him. He became rather
2 agitated and the police really overreacted to his
3 agitation and I think he was restrained, I think CEW,
4 ie Taser, was used and he died. And there was
5 an Inquiry which was led by Judge Braidwood, who was
6 a very senior judge in British Colombia, and he
7 condemned the use of the term excited delirium.
8 Witnesses on behalf of the police attributed the death
9 to so-called excited delirium, the judge wouldn't accept
10 that and there was a very important witness who had
11 worked for the police for over 20 years, he was
12 a psychologist whose name I have just forgotten but it
13 is mentioned --
14 Q. Is that Dr Webster? You mention in the article
15 a Dr Webster who gave evidence?
16 A. Yes. Dr Webster revealed how -- when -- well, revealed
17 how Taser, which is now called Axon, had been promoting
18 the use and the concept -- the use of the term
19 excited delirium and the concept and were very keen to
20 educate police forces about it.
21 Really the way Dr Webster interpreted this, and
22 I think Judge Braidwood as well, was that the more
23 people, especially law enforcement officers, were aware
24 of excited delirium, the more likely they were to use
25 a Taser.

1 So it was really the judge and other witnesses were
2 drawing attention to the use of this term. And the
3 excessive use of the term to account for deaths in
4 custody when other factors should have been taken into
5 account.
6 Q. I think in your article, we can just see at the bottom
7 of the page, if we move that up slightly, that you quote
8 from Dr Webster and say he:
9 "... told the Braidwood enquiry that as a result of
10 Axon/TASER's efforts~..."
11 This was the company involved with the CEW or the
12 conducted energy weapon which you have described as
13 a Taser and Dr Webster said:
14 "... 'police and medical examiners are using the
15 term [excited delirium] as a convenient excuse for what
16 could be excessive use of force or inappropriate control
17 techniques during an arrest'."
18 Does that sum up what Dr Webster said to
19 the Braidwood Inquiry?
20 A. Yes.
21 Q. Then I think you then explain what the decisions were
22 from Judge Braidwood, and you explain the litigation
23 started by Axon and Taser as a result of
24 Judge Braidwood's decision?
25 A. Yes. Judge Braidwood was challenged by Taser on the

1 grounds that he didn't have any scientific understanding
2 of the subject and Axon, Taser/Axon they were overruled
3 on that matter.
4 Q. You say the Supreme Court dismissed the challenge and
5 you give the reference to the case in your article?
6 A. Yes. Yes.
7 Q. Then --
8 A. I was going to say the reason Terry McGuinness and I see
9 that as a pivotal moment, it was when -- it was
10 the Judge Braidwood Inquiry really very publicly
11 discredited the term excited delirium, certainly within
12 Canada, but it continued to be used within
13 the United States. And it was after that that the
14 American College of Emergency Physicians produced their
15 White Paper actually in favour of what they called
16 excited delirium syndrome, and they ignored or defied
17 the Braidwood judgment.
18 Q. I think you deal with that on page 6 in your article and
19 explain the American College of Emergency Physicians'
20 approach and they instituted a taskforce to look at this
21 after Judge Braidwood's inquiries. Is that the
22 organisation -- are they known ACEP?
23 A. That is ACEP, yes. They have recently produced
24 a revised account of what they used to call
25 excited delirium. They've changed the name but

1 essentially they are describing a similar clinical
2 picture. I may have mentioned this this morning,
3 I think I did, I think the reason that emergency
4 physicians, whether in America or in this country, have
5 a different view, say to psychiatrists, of disturbed
6 people is that emergency physicians only see people who
7 by definition are in a very, very severely agitated
8 state whose physiology is likely to be deranged, whereas
9 as psychiatrists we see people who are agitated and
10 upset but whose physiology is not at risk and who need
11 a sympathetic approach rather than a rigorous medical
12 approach. I think that accounts for the discrepancy
13 between the emergency physicians and psychiatrists.
14 I would like to emphasise that that is the basis of
15 the misunderstanding, that the emergency physicians by
16 definition see very, very ill people, and we see
17 a spectrum which includes at the most benign end of the
18 spectrum people who are distressed and upset but who
19 aren't at risk of a fatal outcome from disturbed
20 physiology.
21 Q. Thank you. I think in your own Inquiry statement at
22 paragraph 64 you do mention the American College of
23 Emergency Physicians and you say they have stopped using
24 the term excited delirium and they have simply replaced
25 it with a similar term, hyperactive delirium?

1 A. Yes.
2 Q. Is that the term you were referring to there?
3 A. That is right. That is right.
4 Q. And you say they haven't climbed down from their
5 attitude to excited delirium in spite of the American
6 Medical Association condemning the term and everything
7 it implies?
8 A. Yes, absolutely.
9 Q. In your Inquiry statement you go on to say:
10 "In the UK my understanding is that the
11 Royal College of Emergency Medicine is moving towards
12 the sort of view that I've expressed regarding
13 excited delirium. But I think there is still some
14 resistance and this might be because emergency
15 physicians see severely disturbed people being brought
16 if by ambulance or by the police who need urgent
17 life-saving measures, some of them die and the cause or
18 causes of death are not immediately apparent."
19 So is this --
20 A. Yes.
21 Q. This is what you are referring to in this paragraph?
22 A. Yes. Exactly.
23 Q. Thank you.
24 A. And I think that the Royal College of Psychiatrists and
25 Royal College of Emergency Physicians should not be in

1 dispute about it this, it simply requires a recognition
2 that the emergency physicians are seeing the extreme end
3 of the spectrum whereas as psychiatrists we see a whole
4 range of people who are in very obvious distress.
5 Q. In terms of the work that you did as part of the working
6 group for the Royal College of Psychiatrists, that hope
7 and encouragement to have organisations speak to each
8 other and reach a concurrence and an agreement, is that
9 something you would hope any differences between the
10 Royal College of Psychiatrists and the Royal College of
11 Emergency Medicine could maybe -- that gap could be
12 bridged?
13 A. Absolutely, and in fact I had advocated that in my 2015
14 critique of excited delirium, when I had recommended
15 that because there was obvious misunderstanding between
16 the disciplines of the term excited delirium,
17 I suggested that coroners and medical examiners and
18 pathologists and other professionals should establish
19 a dialogue to work out a reasonable terminology and
20 an approach to highly disturbed people.
21 Q. Thank you. Then in your article you've recognised the
22 divergence of views between America and the UK
23 for example. You also talk about greater scrutiny in
24 Europe and you describe two reports published in 2017
25 which cast further doubt on claims of deaths due to

1 excited delirium and you mention:
2 "The use of restraint by police forces in the UK
3 featured prominently in Dame Elish Angiolini's report on
4 deaths in police custody. Her review was commissioned
5 in 2015 by the then Home Secretary, Theresa May, after
6 meeting with families of Sean Rigg and
7 Olaseni Lewis~..."
8 A. That is correct.
9 Q. Both had died after restraint by the police?
10 A. Yes, and there are two points that stand out in the
11 Angiolini report. One is that she condemns the use of
12 the term excited delirium, and secondly she condemns the
13 use of prone restraint.
14 Q. You've detailed her recommendations and her views in
15 your article and you say:
16 "She also called for the term to be removed from
17 guidance to police officers."
18 A. Yes. That is right.
19 Q. Thank you. Then I think earlier today you were talking
20 about percentages of deaths, and I see on page 7 of your
21 article towards the bottom of right-hand side you say:
22 "Although the ACEP taskforce had recommended that
23 a diagnosis of ED be based upon evidence of perceived
24 abnormal behaviour and at least six of their ten
25 potential clinical criteria for such a diagnosis, a team

1 from Lausanne University Hospital who reviewed matters
2 found many patients had been diagnosed with
3 excited delirium despite presenting with fewer than six
4 of the diagnostic features."
5 Is that something that you were -- you mentioned
6 earlier in evidence today?
7 A. Yes. Fewer than six and in some reports just a single
8 feature.
9 Q. You go on to say:
10 "The most common features, including claims of
11 superhuman strength, bizarre behaviour and unusual pain
12 tolerance, did not appear with equal frequency and
13 appeared not to be mandatory."
14 So not mandatory parts of the criteria?
15 A. Yes, exactly.
16 Q. You concluded:
17 "The prevalence of excited delirium also appeared to
18 vary widely with context."
19 Is that an indication of the lack of standardised
20 criteria or just in general?
21 A. Yes, two points. Yes, lack of standardised criteria, or
22 the fact that the criteria could be very subjective,
23 for example how do you gauge tolerance to pain? The
24 other thing is you used the word context. That is very
25 important and a subsequent paper by Strömmer,

1 Ellen Strömmer, which came out only a year or two later
2 in which she emphasised -- she reviewed all the case
3 reports on excited delirium in the literature and she
4 established that the term excited delirium as a cause of
5 death was only used when what she called aggressive
6 restraint had been used. So the context was aggressive
7 restraint leading to death, and at that point the cause
8 of death would be excited delirium.
9 That was an extremely thorough review of all the
10 available literature.
11 Q. Strömmer is also mentioned in your article and the --
12 A. Yes.
13 Q. Yes, yes. We see that at the bottom of page 7. Then
14 you also comment:
15 "Whilst cases requiring out of hospital restraint
16 were observed in fewer than two cases for 10,000
17 emergency calls for advanced life support,
18 excited delirium was associated with more than 10% of
19 deaths in police custody and said to represent more than
20 10% of CEW [Taser] related deaths."
21 I am interested in the distinction there in the
22 figures, in the statistics: observed in fewer than two
23 cases for 10,000 emergency calls but more than 10% of
24 deaths in police custody.
25 A. Yes. Indeed, so -- and then Strömmer breaks down what

1 happened in police custody and she divides restraints
2 methods into "aggressive restraint methods", which in
3 the American context meant neck holds, choke holds,
4 huddle position, hog tie -- so she calls those
5 aggressive methods of restraint -- from more gentle
6 methods of restrain, and excited delirium as a cause of
7 death was pretty well invariably linked to the more
8 aggressive methods of restraint.
9 Q. You also say on page 8 of your article:
10 "The absence of a clear, consistent definition has
11 made it difficult to estimate the incidence
12 of excited delirium and has prevented a consensus
13 emerging as to its mortality rate. On the one hand,
14 there is the conviction that people presenting with
15 these signs were always doomed, unable to alight from
16 the 'freight train of death'."
17 You talk about that being seen in certain
18 publications from Wetli, Mash and Karch. I am
19 interested in what it means, this "freight train of
20 death"?
21 A. By that -- that was their term and they meant that once
22 you are in an excited state, then you are going to die
23 anyway, regardless of the way you are treated.
24 Q. And that is the view of people who support
25 excited delirium being used as a cause of death?

1 A. Absolutely, so the death rate in excited delirium --
2 from the proponents of excited delirium was claimed to
3 be, to range between you know 100% to 10% roughly, which
4 seems absurd.
5 Q. Then you talk about the future, this is in your 2022
6 article, and at the bottom of page 8 on the right-hand
7 side you say:
8 "The American Psychiatric Association Board of
9 Trustees adopted a position statement in December 2020
10 which declared that excited delirium should not be used
11 as a diagnosis because it is non-specific and lacks
12 clear diagnostic criteria ... The statement noted that
13 excited delirium 'had been invoked to explain or justify
14 injury or death to individuals in police custody' and
15 that the term is disproportionately applied to black men
16 in police custody."
17 A. Yes.
18 Q. That is something you mentioned to us earlier?
19 A. Yes. Yes.
20 Q. Then you talk about the position in England and Wales at
21 that time. Now, you've also talked about the
22 Royal College of Emergency Medicine in the UK and their
23 apparent moving towards a change in position at this
24 stage as well?
25 A. Well, they've abandoned the use of the term

1 "excited delirium", they've adopted the term "acute
2 behavioural disturbance", which is a good move, but
3 there is a danger, and this has happened in at one or
4 two inquests, specifically the one I can think of is
5 Kevin Clarke, where pathologists have proposed that the
6 cause of death during restraint in a psychiatrically ill
7 patient was acute behavioural disturbance, whereas the
8 evidence was accepted that it was faulty restraint that
9 led to his death.
10 So we are concerned, it is my concern and I know
11 that the charity Inquest is concerned and other people
12 are concerned, that ABD, acute behavioural disturbance,
13 might be used in the way, almost as a synonym for
14 excited delirium as a cause of death in a way that
15 minimises the contribution of faulty restraint.
16 Q. I would like to move on to page 9 of your article which
17 covers your conclusion and I would like to read part of
18 it out and then ask you some further questions about
19 this, if I may. Because you say you:
20 "... recognise the risk that the term ..."
21 Towards the bottom of the page on the left:
22 "... we recognise the risk that the term acute
23 behavioural disturbance might be misused at enquiries or
24 inquests as a proxy for excited delirium, to downplay
25 the role of faulty and negligent restraint. We are

1 concerned that at the recent inquest into the death of
2 Kevin Clarke a 35 year old Black man who was
3 experiencing a severe mental health crisis in a public
4 place, the jury recorded the primary medical cause of
5 death as 'acute behavioural disturbance (in a relapse of
6 schizophrenia) leading to exhaustion and cardiac arrest
7 contributed to by restraint struggle and being
8 walked'~... We would tentatively suggest ABD's
9 replacement with an adjectival description, such as
10 'severely agitated person in distress' (SAPID could be
11 used as an emergency services call sign). Like
12 excited delirium before it, the misappropriation of the
13 term acute behavioural disturbance must not be allowed
14 to downplay the threat that faulty restraint poses to
15 life in these highly challenging situations."
16 I am very interested in hearing more about your use
17 of this, if I can use the acronym SAPID, severely
18 agitated person in distress. Could you tell us why you
19 think that would be a better description or better
20 terminology than excited delirium or ABD?
21 A. This was an acronym that I thought could be used as
22 a call sign to draw attention to the individual person
23 as being a person in distress rather than emphasising
24 a condition. Sort of legacy of excited delirium is that
25 there is a suggestion that there is a specific entity

1 which in itself can have a fatal outcome as opposed to
2 what I would prefer, and I think the College would
3 prefer, the College of Psychiatrists would prefer, is
4 an adjectival description, a more humanising description
5 of what we witness in a person and what a person's
6 experiencing as opposed to a diagnostic entity.
7 So -- and I am talking about the, as it were, benign
8 end of the spectrum in which a person can become
9 severely distressed when they hear bad news or something
10 goes seriously wrong in their personal life and so
11 what we witness, what we see, is not a condition, not
12 a diagnosable condition, but in everyday human life
13 terms a person who is extremely upset and distressed.
14 I think that is the advantage of that acronym SAPID. It
15 replaces an alleged diagnostic entity with a description
16 of the human being in distress.
17 Q. So moving away from the idea that excited delirium or
18 ABD are conditions that can be diagnosed and putting the
19 focus on the person?
20 A. Yes, exactly.
21 Q. Thank you. I would like to move on and ask you some
22 questions -- you've already touched on this, this
23 morning, when I was referring to your original report to
24 PIRC. We talked about the state of mind of a person who
25 has taken Alpha-PVP, MDMA, who is becoming agitated and

1 perhaps psychotic and you gave your diagnosis in your
2 original report of the intoxication that that person is
3 experiencing. We talked about the state of mind of that
4 person -- in particular Mr Bayoh when he was at his
5 friend's house -- becoming paranoid, and we also talked
6 about the state of mind when he was involved in the
7 altercation, the fight with his friend.
8 A. Yes.
9 Q. I would like to ask you for your comments about the
10 state of mind during different phases of the events.
11 We've obviously heard a lot of evidence in the Inquiry
12 from eyewitnesses and civilians and police officers.
13 We've heard evidence from a pathologist and we have
14 heard evidence from experts. I wonder if you could help
15 the Chair understand the state of mind of Mr Bayoh when
16 he was walking through the street, said to be seen to be
17 brandishing a knife, chasing cars, walking in -- I think
18 you described earlier in a confused fashion. And then
19 I would like you to explain the state of minded when the
20 police arrive.
21 So we've heard evidence about the arrival of the
22 police vans, police vehicles arriving, officers in full
23 uniform, sirens, claxons, and some of the officers
24 shouting commands. Can you give the Chair any
25 additional information about the state of mind of

1 a person when that takes place, when the police arrive
2 at the scene?
3 A. If a person is in a paranoid state, as I defined it this
4 morning, that is to say a person whose thinking is
5 dominated by imaginary enemies, by the idea that other
6 people are out to harm you or kidnap you or torture you,
7 then -- then you are highly suspicious of other people,
8 including people in authority.
9 Now, I don't know Mr Bayoh's previous experience
10 with the police, and he might not have had any previous
11 experience, but sometimes the appearance of somebody in
12 a uniform exacerbates a paranoid state, whereas a person
13 appearing as a civilian might be potentially reassuring.
14 I think I must mention ethnicity. I know that
15 Scotland has a more tolerant reputation than England
16 when it comes to racial prejudice but it is possible
17 that Mr Bayoh had experienced discrimination and that
18 might have been a factor when he was approached by white
19 police officers. I simply don't know that. That's
20 speculation that has to be considered.
21 I think -- well, I think -- I hope that answers your
22 question. We do -- the other thing I would emphasise is
23 that, in this drug-induced confusional and paranoid
24 state, a person's attitudes fluctuate, and level of
25 disturbance fluctuates. This must be to do with what is

1 going on in biochemistry and neurochemistry. So we know
2 that he had what seems to be a reasonable conversation
3 with a neighbour, Mr Morgan, which was very, very
4 different to the fight, serious fight, that he had with
5 his best friend. So that has to be taken into account,
6 the possibility of fluctuations in his degree of
7 confusion, his misinterpretation of what was going on
8 around him and how he understood other people's
9 intentions.
10 Q. The Chair has evidence available to him by way of
11 a statement from Mr Bayoh's friend, Mr Saeed, who talks
12 about Mr Bayoh's behaviour switching -- he used the word
13 "switched" -- and his body language becoming different.
14 He described it as:
15 "He would become quite sturdy and firm, his eyes
16 sort of switched."
17 Is that the type of thing you are talking about when
18 you use the word "fluctuating"?
19 A. Yes, indeed. This variability in his mental state, in
20 his disorientation, and in his paranoia from almost
21 minute to minute. That certainly happens in a drug
22 induced state.
23 Q. Then as you mention we've heard evidence from
24 Neil Morgan who knew Mr Bayoh, he was a neighbour of
25 Mr Bayoh, who spoke to Mr Bayoh after the altercation,

1 the fight with his friend, and that seems to have been
2 a calm conversation between the two of them. Again,
3 would that be explained by the variation, the
4 fluctuation that you are talking about?
5 A. Yes, indeed. But it may also have been due to
6 a difference in approach. I'm not forgetting that he
7 attacked in a very serious way his best friend but he
8 then had a reasonable -- reasonably sort of amicable
9 conversation with Mr Morgan and went on to a struggle
10 with the police.
11 So the struggle with the police might have been
12 paranoia-based, it might have been a person feeling that
13 the police were hostile to him and that his life might
14 be in danger. Even -- what I am saying is even in the
15 absence of paranoia one comes across people, this is
16 well-documented in the United States, people who are not
17 psychologically disturbed but who are approached by
18 the police -- I am talking about black people now -- and
19 who then are so terrified of the police that a life and
20 death struggle ensues. And that is to do with
21 a previous experience of racism.
22 Q. I will come back to that in a moment, but you used the
23 words "different", it could be a different approach.
24 So we've talked about the fluctuating reaction, we
25 have talked about the description of him "switching"?

1 A. Yes.
2 Q. The sort of psychological change. In what way -- when
3 you were talking about a different approach in relation
4 to Mr Morgan, what was it you were thinking could have
5 been significant there?
6 A. Mr Morgan would probably recognise that Mr Bayoh was in
7 some sort of distressed state. And in a friendly
8 neighbourly way would have said probably something like
9 "Are you all right?" You know, "Let's have a chat",
10 would have said something reassuring, and reasonable
11 rapport would have been established. I guess Mr Morgan
12 had the advantage of not being in police uniform.
13 Q. Indeed, we heard evidence from Mr Morgan that he had
14 invited him in to have a cup of coffee and to calm down.
15 A. Yes.
16 Q. You mentioned just a moment ago racism, experience of
17 that, and we did hear evidence from Mr Bayoh's partner,
18 and she talked about a conversation she had had some
19 time ago with Mr Bayoh or conversations and had said:
20 "Shek used to always say to me that -- about racism
21 and the police~..."
22 And she described how she was very naive to these
23 things:
24 "... and he had said, 'Do you know as a black man
25 when you're up against the police it doesn't matter if

1 you have done right or if you've done wrong, the only
2 way you're getting out from a confrontation with the
3 police is if you run. There is no way out as a black
4 man when you are coming up against the police'."
5 So that is maybe not a detailed discussion of the
6 conversation they had had, Ms Bell and Mr Bayoh, but
7 could that be indicative of someone who has had
8 previously bad experiences with the police?
9 A. Yes. I wasn't aware of that at all. But that is
10 exactly what I was referring to when I said that
11 an individual might have been sensitised by previous
12 negative -- by one previous negative or multiple
13 previous negative encounters with people in authority,
14 with the police.
15 Q. Then in that situation where the person is intoxicated
16 by these drugs, and is perhaps suffering from this
17 paranoia, if the police then of course discharge CS and
18 PAVA spray, and strike that person with batons, in terms
19 of the state of mind of the person can you explain to
20 the Chair how their state of mind would develop or
21 evolve as these things happen?
22 A. Yes. A person who is not suffering from a mental
23 illness, who is not intoxicated, but who has a previous
24 experience of racism or is aware of police attitudes to
25 black people -- so I am talking about a person now,

1 a black person, who is not unwell, but they might be
2 very frightened indeed when they are questioned by the
3 police because they will be aware that there are
4 occasions when the police have acted excessively or
5 unlawfully in relation to people of colour, and that
6 will make them frightened and apprehensive and if
7 a struggle develops they might feel this is a life and
8 death struggle.
9 I think this is one of reasons for the label
10 "superhuman strength", the individual resists because
11 they are truly in fear of their lives, and the more they
12 resist, the more restraint is applied so it's a terrible
13 vicious circle.
14 Now, that's a person without mental illness and
15 without intoxication. When you have mental illness
16 and/or intoxication, as in this case, and where we know
17 that there's paranoia, as we mentioned earlier, these
18 ideas of reference and the suspicion that a friend was
19 in the CID and so on, then the suspicion and the fear
20 are compounded, multiplied enormously. So the reaction
21 will be even more intense.
22 Q. If we have heard evidence of Mr Bayoh struggling in
23 an extreme way against the police restraint, so having
24 been brought to the ground by a number of police
25 officers and I quote:

1 "Actively resisting with extreme force and throwing
2 punches ..."
3 Is that the type of reaction that someone suffering
4 from a psychotic -- paranoid and under the influence of
5 these stimulant drugs, is that the type of reaction you
6 would expect if they are being restrained?
7 A. Yes, indeed. So that is in the -- in a psychologically
8 abnormal state induced by drugs or mental illness.
9 But I do want to emphasise that people -- black people
10 who are not unwell -- I am talking about men mainly, who
11 are not unwell but who are inappropriately apprehended,
12 they may struggle to escape because they feel that the
13 outcome for them is going to be very bad. So they may
14 perceive an arrest as potentially a life and death
15 struggle.
16 Q. Based on their --
17 A. So I am talking about both people on the one hand with
18 mental illness and/or intoxication but I am also talking
19 about young black men who don't have an abnormal
20 psychiatric state.
21 Q. So black men who have experienced discrimination, who
22 see themselves as in a life or death struggle even
23 without having taken any --
24 A. Yes.
25 Q. -- any drugs would struggle --

1 A. Absolutely.
2 Q. -- against that?
3 A. Absolutely.
4 Q. And if someone has taken drugs, that would be an even
5 more extreme reaction by that same person?
6 A. Exactly. Yes. That is exactly the point.
7 Q. Thank you. I'd like to ask you about something else you
8 said earlier today. You were talking about
9 de-escalation. We've heard evidence from experts in
10 relation to police tactics and restraint, and two
11 scenarios were discussed as part of that evidence.
12 Well, four actually. But two of them involved no
13 engagement as such by the police. Two of them involved
14 engagement by the police.
15 One scenario was described as de-escalation. And --
16 if you can give me a moment -- this was a scenario where
17 the officers would:
18 "... engage and negotiate and de-escalate in
19 relation to the person, try to understand what was going
20 on, to allow them to inform decision-making about the
21 process ... an opportunity to communicate ... key to
22 building rapport and they would attempt to de-escalate
23 engage and negotiate."
24 If we can call that the de-escalation scenario.
25 Then another scenario being what was known as verbal

1 dominance or colloquially called "a hard stop":
2 "... an authoritarian approach wanting to try and
3 control the individual ... a verbal dominance approach
4 of communication. A methodology of trying to dominate
5 the individual by getting them to comply with
6 instructions to minimise the risk or minimise the
7 requirement to possibly use other force."
8 So two different tactical options, one called
9 de-escalation, one called verbal dominance or a hard
10 stop.
11 I wonder if you could help the Chair understand the
12 difference in those approaches if dealing with someone
13 who isn't under that intoxication with that paranoid
14 state of mind.
15 A. The first approach is the one that mental health workers
16 would use, psychiatrists, mental health nurses and so
17 on, and we would not use -- make an attempt to dominate
18 by using commands and orders because it's fairly obvious
19 that it's likely to alienate and antagonise the person
20 and if they, as they often are, are paranoid and
21 suspicious and frightened, that is likely to make them
22 even more frightened. So I would go for the other
23 option, which involves an attempt to listen, and not to
24 appear threatening but to offer reassurance and, as
25 I said earlier, not to appear to be in a hurry but to

1 give the impression that we have plenty of time to
2 listen to the individual's point of view and to find out
3 what in particular, what they are worried about and to
4 see if we can do anything about their worries.
5 So in my statement I gave an example which was
6 a person may say, "Well, I'm very worried because
7 somebody is -- some conspirators are attacking my wife
8 and children at home", and then we as mental health
9 workers might say, "Well, look, there's something we can
10 do about that, we'll get the social workers to go around
11 to your house now just to check on their safety and as
12 soon as we have got the news we will give it back to
13 you". So that would be an attempt to provide practical
14 reassurance and to respond to the person's false beliefs
15 but taking them seriously at the same time and doing
16 something about it. Within our power.
17 Q. Thank you. Then in your Inquiry statement, if I can
18 look at paragraph 66, please, you say:
19 "In summary I state in my 2016 article that there's
20 no evidence that acute behavioural disturbance alone is
21 other than a rare cause of death and there is no
22 evidence that, correctly restrained, behaviourally
23 disturbed patients are commonly at risk of death. The
24 majority of cases will survive arrest, restraint and
25 being transported to custody or to hospital."

1 I'm interested in any views you have about how
2 significant the manner of dealing with people in these
3 states is in terms of the eventual outcome.
4 A. Yes. If you use the de-escalation approach which we
5 have been discussing, then you are much more likely to
6 have a patient -- I am using the word patient --
7 a patient who will be co-operative and who will become
8 less agitated, and who you can establish a rapport with,
9 and indeed who will calm down. The calmer you are, the
10 less physiologically disturbed you are and so the
11 outcome is likely to be a satisfactory one.
12 If, conversely, you appear threatening, domineering,
13 dismissive -- dismissive is an important word in this
14 context, if you don't look as if you have the time to
15 listen to what the patient might want to say, then you
16 are going to make the situation worse and the person
17 will become more agitated and regard you as -- you, the
18 intervener, as a threat rather than a source of help and
19 reassurance.
20 Q. So would that approach exacerbate the symptoms they are
21 feeling or experiencing?
22 A. Yes. Yes.
23 Q. Then I am also interested in another section your
24 Inquiry statement at paragraph 74. You say:
25 "Once you have decided that restraint is needed ..."

1 I think earlier you recognised that there may be
2 occasions or circumstances where that -- although you
3 say the final option, that is an option that has to be
4 taken. So:
5 "Once you have decided that restraint is needed,
6 then you need an ambulance straightaway."
7 I am interested in the significance of obtaining
8 an ambulance straightaway. Can you tell me a little
9 more about that; why would you suggest that?
10 A. Because the restraint process itself, which is often
11 associated with a struggle against restraint, causes the
12 person's physiological system to go into an abnormal
13 state. So it's unlike a typical athletic exercise like
14 running or swimming et cetera, where there is
15 a physiological adaptation, when you are struggling
16 against restraint that is a highly abnormal state and
17 the physiological response is risky and perilous. So
18 the sooner you get the person to appropriate medical
19 help, and this is where emergency physicians certainly
20 come in, they will be able to assist in correcting the
21 abnormal physiology.
22 Q. Thank you.
23 A. And the way to do that is to get people to hospital,
24 ideally in an ambulance because the ambulance staff will
25 be able to monitor the individual's heart rate, oxygen

1 levels and so on.
2 Just to pick up on something that was mentioned
3 earlier, in my 2015 paper I said a person should be
4 taken into custody or into A&E. Ie that is at a time
5 when a place of safety was defined as custody or A&E.
6 So that is out-of-date, I would now of course say they
7 should go straight to -- be taken straight to A&E by
8 ambulance.
9 Q. So if there is a decision taken that restraint is
10 necessary, when would you be recommending that
11 an ambulance is called?
12 A. Straightaway.
13 Q. Thank you.
14 A. Immediately.
15 Q. Immediately. Now, finally the Chair has an Inquiry
16 statement and we've heard some evidence from the
17 pathologist in relation to comments and opinions
18 expressed by a Dr Steven Karch, and my understanding is
19 that you and he are of different disciplines, and you
20 have a divergence of views in relation to
21 excited delirium. Just so that the Chair is in
22 no doubt, can you explain the differences between your
23 view and that of Dr Karch, please?
24 A. Yes. As you have just said, I am a psychiatrist, so
25 I deal with mental illness and Dr Karch is a forensic

1 pathologist and he examines bodies, trying to establish
2 cause of death. He has a particular interest I think in
3 cardiac causes of death. So I have my area of expertise
4 which is totally different to his. Where our views have
5 clashed is that for many years he has been a strong
6 proponent of excited delirium as a cause of death in
7 custody and, as I have been saying throughout today,
8 I take the opposite view.
9 Q. I've read the Inquiry statement that he has provided to
10 the Inquiry and, just for the avoidance of doubt,
11 I don't understand him to claim to be a forensic
12 pathologist. My understanding is he describes himself
13 as a cardiac pathologist. My understanding is that he
14 is not carrying out post mortems, but his particular
15 interest is in cardiac and the heart.
16 A. I have read many articles by Steven Karch and I think
17 they have -- apart from one article in the journal of
18 the Royal Society of Medicine, the others have all been
19 in American journals which have "forensic" and/or
20 "legal" in the title. So forensic and legal pathology
21 and variations on those titles.
22 Q. Right. We have a very detailed Inquiry statement from
23 him and the Chair will be able to consider his own
24 experience and qualifications in due course. But thank
25 you very much. Could you give me one moment, please,

1 Dr Lipsedge.
2 A. Yes.
3 MS GRAHAME: Thank you very much. I have no further
4 questions.
5 LORD BRACADALE: Dr Lipsedge, I am going to speak to the
6 legal representatives here for a moment, so I am going
7 to cut the connection with you just now. But don't go
8 away because I will come back to you shortly and explain
9 to you what will happen next.
10 A. Yes, sir.
11 LORD BRACADALE: Are there any Rule 9 applications? No.
12 Perhaps we could have Dr Lipsedge back on as soon as
13 possible. (Pause).
14 Dr Lipsedge, I have come back to you sooner than
15 I expected to, but I am able to tell you that there will
16 be no further questions for you.
17 A. Yes.
18 LORD BRACADALE: May I thank you very much for giving
19 evidence to the Inquiry. I am very grateful to you for
20 taking the time to do that. We are going to rise now
21 for the day, and you will be free to go about your own
22 business again. Thank you very much.
23 A. Thank you, sir.
24 (The witness withdrew).
25 LORD BRACADALE: Thank you.

1 (3.03 pm)

2 (The Inquiry adjourned until 10.00 am on

3 Tuesday, 16 May 2023)

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