Thursday, 1 December 2022

(10.29 am)

LORD BRACADALE: Good morning. I'm sorry there has been on a delay this morning. There was a difficulty with the link to Opus 2, but that has now been resolved.

Before we continue with the evidence I wish to address the legal representatives. I have three matters to mention:

First, yesterday at the close of business Ms Mitchell drew my attention to an incident earlier in the afternoon in which in the course of evidence a legal representative appeared to use a mobile phone for a purpose clearly unrelated to the proceedings of the Inquiry. While that was a particularly egregious example, it was not the first occasion on which the sound of mobile phones has disturbed proceedings.

I have no difficulty with mobile phones being used silently to make communications on matters relating to the Inquiry, but inappropriate use within the hearing room is both distracting and disrespectful.

Second, I have received representations about legal representatives engaging in lengthy conversations during the evidence. This can be distracting to others in the hearing room and to those watching on YouTube. While I accept that occasionally it will be necessary for

legal representatives to speak to each other during the proceedings, I remind them that as well as using mobile phones silently, as I have just suggested, there is a facility on Opus 2 for having private conversations.

Third, I have received representations to the effect that certain legal representatives have, on occasion, reacted to some of the evidence by adopting inappropriate facial expressions. If that has been happening it would, on any view, be very disrespectful and wholly unacceptable.

May I remind legal representatives that these proceedings are being broadcast and watched around the world. It is therefore as surprising as it is disappointing to have to address members of the Scottish legal profession in these terms. I very much hope that I will not have to do so again.

Thank you for your attention. Could I have the witness in, please.

MS JOANNE CAFFREY (continued)

LORD BRACADALE: Good morning, Ms Caffrey. I'm sorry of you have been kept waiting. We had some difficulty with the link to the transcription service this morning.

A. That's okay, sir.

LORD BRACADALE: Ms Grahame.

Questions from MS GRAHAME (continued)

MS GRAHAME: Thank you.

Ms Caffrey, good morning.

A. Good morning.

Q. Yesterday we were looking at the "Use of Force Standard Operating Procedure" --

A. Yes.

Q. -- as I asked you questions, and I wonder if we could have that back on the screen, please. That's PS10933 and we were focusing on 4.6 and 4.7, "Profiled Offender Behaviour" and a reasonable officer response. There we are, 4.6, and we had begun to discuss a scenario where officers use strong verbal commands, but the subject does not comply --

A. Mm-hmm.

Q. -- and you had indicated, in relation to the scenario I put, which was: the subject was already walking towards the officers when they got out of a van, they park in his path, he is not aiming at them as such, but he continues walking, does not move and does not divert away from them. So that was the scenario that we were discussing at close yesterday.

A. Yes.

Q. You identified that offender behaviour as level 2 --

A. Yes.
Q. -- if they failed to comply, which we can see on the screen there at 4.6.3, "Level 2 - Verbal Resistance and/or Gestures". And you said, as I understand it, that a reasonable officer would be considering a level 2 response and we will see that at 4.7. So there's the "Officers reasonable response" at 4.7 and level 2, if we can just move down the screen, "Tactical communications" and that would be within that -- the range of options within the tactical communications level --
A. Yes.
Q. -- and I think you agree that that -- where to pitch that response by the officer would be a matter for their discretion, tailored to the particular circumstances they faced.
A. Yes.
Q. Thank you. Before we leave this scenario, may I return to the question: if a reasonable officer is faced with level 2 behaviour, would a reasonable officer consider using a level 4 response, namely using their CS or PAVA spray?
A. I don't believe so.
Q. Why do you say that?
A. Simply because looking at proportionality, if the person's at level 2, they're not actually being a threat

to the officer and the idea of level 4 is it's a defensive tactic, so it's used in defence of the officer, or defence of another person, or all other options have been discounted because of the severity of the incident.

Q. And just looking at level 4, just if we can move that on to the screen for the moment, this is a defensive tactic -- if we can move up slightly, thank you:

"These tactics are generally perceived to be strikes, whether delivered by ... empty hand techniques or baton strikes, but also include the more robust defensive handcuffing techniques and the use of CS Incapacitant Spray."

Again, in relation to a level 4 response, would it be reasonable to assume that, again, there's a range of options open to a reasonable officer in adopting a level 4 response?

A. Yes.

Q. And it describes the use of spray as "a more robust defensive handcuffing technique", or the -- and the use of spray.

A. Yes.

Q. Are they the more robust ranges of options within that defensive tactic level?

A. They can be. It's the decision -- because you could say

"Well, the open hand techniques could be more robust", it would depend on force levels and some concepts by using the CS, for example, can avoid the physical impact, so depending on the circumstances, CS use could prevent physical injuries, but CS brings about its own potential injuries and risks as well.

Q. I will come on to that in a moment.

If a reasonable officer is endeavouring, or trying, to adopt the minimum level of force in response to level 2 behaviour by the subject --

A. Yes.

Q. -- what options would be open to that officer?

A. So, defensive tactics would be as simple as hands up (indicating) and being prepared to push the person backwards. It would also give the opportunity for an officer to back off as well because that's within an officer's response options as well: hands up ready to protect, but also backing off at the same time, whilst using verbal communication.

Leading up that, if it was to be an engagement and, for example, the arrest process, then you would be looking at getting -- taking a hold of the person and moving into some kind of restraint technique, which could either be hands alone, so for a physical technique, or it might be that if that's too high a risk

they decide then that they will use such as the CS or the baton.

Q. What difference would it make to the options open to an officer, a reasonable officer, if there is concern that the subject had a weapon, perhaps concealed?

A. If there's belief that they've got a weapon the last thing you want to really be doing is being within close contact because the weapon can soon be produced and the officer can be stabbed and even though you might have the stab vest on, they only go down so far and they only cover so many of the major organs. It still doesn't prevent you being stabbed in an artery in like the thigh, for example, or within the arms, or within the neck area, here. So certainly you want to keep your distance from a person who you think has got a weapon because of your own personal safety.

Q. Thank you. You mentioned that sprays themselves have potential -- the potential to injure the subject or others.

A. Yes.

Q. Could you tell us a little about those potential injuries?

A. So, for example, a person who has been sprayed, in relation to say, for custody, they are considered a higher risk detainee because of the impacts that can

happen. From the physical aspects we've got potential for -- some people can suffer a kind of burn to the skin from them, but a main impact is panic and breathing can be affected as well, so for some people that are highly sensitive to the chemicals that are used within either CS and PAVA and the spray can affect their breathing capabilities, so particularly then if you've got people with other conditions such as asthma, angina, you know, those then would increase the risk further for the person.

Q. And is there a difference, if it's CS or PAVA?

A. Well, CS works by -- you can get CS on clothing, or even you could have CS on you and I could be affected here by it. Different people are sensitive to it in different ways.

The PAVA works more on the actual individual that it strikes and it needs to be striking them in their eyes rather than the effects of the spray coming off, coming off -- the molecules coming off the actual spray.

Q. And we may have heard evidence at the first hearing that some people can become more agitated or aggressive as a result of --

A. Yes.

Q. -- having spray discharged towards them or on them.

A. Definitely, yes.

Q. Is that the case?
A. Yes, and it can disorientate people as well, disorientate them, because your eyes will typically need to shut because of the pain that they can cause, so the person then, if they're disorientated, now can't see and that also affects then -- sorry, impacts upon the police officers, because if they get the impact of the CS it can also blind them and make them go into panic as well.
Q. And we have heard that sprays can -- the impact of the spray, or the effectiveness of the spray, can be affected by the weather --
A. Yes.
Q. -- and the wind.
A. Yes.
Q. I would like to move on and ask you about -- taking the situation further now. If CS and PAVA sprays have been used by the officers, so have been discharged towards the subject, but the subject fails to react to either CS or PAVA spray and continues to walk away from officers, thinking again about the categories of behaviour, just in that moment --
A. Yes.
Q. -- how would a reasonable officer categorise the behaviour of the subject at that point?

A. So that then, when I mentioned yesterday about all these little mini check sheets that you're thinking about when you're dealing with things, that alone would be ticking off things like high intoxication potential, mental ill health crisis potential, which then would link to the likes of the ABD potential, or it's one of these rare people who it just doesn't affect, but the majority of the time the reason it doesn't affect tends to be because of intoxication or mental health crisis.

Q. And, I think you explained yesterday, but just for completeness, if a reasonable officer is considering intoxication or mental health crisis, what does that reasonable officer do?

A. Notify his control for medical attention.

Q. And you mentioned the ABD. Again, could you simply remind us what that is?

A. So that's "acute behavioural disturbance" and that terminology, certainly within the police in England and Wales -- prior to that it was "excited delirium" was the common terminology and then in 2002 the Police Complaints Authority published a report and a decision to -- because there were so many different kinds of delirium, they wanted to use one umbrella term, which then they looked at acute behaviour disturbance, so it didn't matter then, medically, what kind of delirium it

was, it would just all be accumulated under this one heading, and at the end of the day, police officers are not medical professionals. Therefore, it's just those risk factors and a generalisation of thinking "This could be that", and then looking at the control factors around those risks.

Q. So if at this stage, in the scenario we're discussing, we have reached a stage where the sprays have been discharged and the subject has failed to respond, what signs may have existed which a reasonable officer could identify at that point?

A. So there you've got the collection of things now: you've got the bulging of the eyes, you've got the inappropriate clothing for the weather conditions, you've got the lack of communication and response to the officers, you have then got the CS and PAVA not working, so all of that together then is -- there's more evidence to indicate this is a medical requirement.

Q. And if a reasonable officer identifies a number of warning signs and considers the possibility that the person has ABD, or intoxication or mental health, what would they do in response to that?

A. They must be dealt with as a medical emergency if there's any indication or suspicion of ABD.

Q. So even any suspicion of the ABD?

A. Yes, yes, because the police officers can't confirm it is or it isn't.
Q. Right. And again, does that mean contacting ACR on the radio asking for an ambulance?
A. Yes, yes.
Q. And as well as the factors you have mentioned, to what extent would a reasonable officer recognise behaviour that members of the public had phoned up and complained about as a factor?
A. I think police officers should be quite well-practised in recognising it because the amount of people that police officers are dealing with on a daily basis, plus the amount of -- percentage of those people who are then under the influence, or suffering with mental health crisis, I think a police officer -- a reasonable police officer would readily identify that the person may be experiencing either or both.
Q. To what extent would a reasonable officer, at that moment, consider pulling back or withdrawing from the subject?
A. Well, that would certainly be the reasonable officer's instruction to do so because, certainly with officer safety training, the emphasis is in relation to a person suspected of ABD is that "contain" rather than "restrain". The moment you go into a restraint with

a person who is suffering from a delirium condition, it significantly increases the risk of death during restraint.

Q. Death to whom?

A. To the subject.

Q. Right. And can you explain what, if any, defensive controls a reasonable officer would have open to them?

A. So, it's -- it's the body posture, it's the containment, it's the dog, it's the -- it's the use of the baton, for example, as a swing to try and keep the distance between you and the person, so they would all still be a defensive tactic, but without physically touching or restraining the person.

Q. And to what extent would a reasonable officer engage in a physical restraint, or touch the person, if they have those concerns?

A. Well, the training is all focused on: you don't restrain that person. It would be the absolute, sort of, final straw to restrain that person because all other options have either tried and failed or been discounted. So then once if you went to the restraint there would be all the control measures around that.

Q. What -- we will come on to that in a moment. What if the reasonable officer suspects that the person may have a knife on their person, although it is not visible?

A. Again, if you believe a person has got a knife on them, the last thing you want to do is be in close contact, particularly then if the person is intoxicated or in crisis because there might be issues around their capacity to understand what's happening and their thought process and so you could be at a higher risk of actually being stabbed by the person as well.

Q. And if a reasonable officer is seeking to adopt the minimum level of force, what would that reasonable officer be likely to do?

A. It would be trying to just keep a containment and keep the person contained in the space.

Q. What would they do in terms of communicating with --

A. Talking, constantly talking, trying to offer help, asking the person to be calm, to talk to them. It would be trying to -- trying to impart non-aggression because if the person is in crisis you don't want to aggravate a person, or instill extra fear in them.

Q. And why would you not want to do that?

A. Because then the person can become either aggressive towards you, or more unpredictable in their behaviour and again, they could try and flee the area which then displaces the risk and may put members of the public at increased risk.

Q. And if, during that moment in time, there is a dog unit

available, what difference could that make to the options open to a reasonable officer?

A. That the dog can easily contain a person and the officers then can back right off and the dog can then -- the dog's got the ability to keep going around the person and to keep them quite contained until the person then gives up. Then once the person has given up and sort of gone to their knees, put their hands up, the officers can then move on in and handcuff and bring the hands round and then a search of the person can be conducted.

Q. Thank you. And again, if a reasonable officer is endeavouring to observe the principle of preclusion, what would -- the process they would go through?

A. It would be rapidly thinking about how can you resolve this and bring it to a safe conclusion without the use of force, if at all, or what's the minimal use of force, so you're constantly thinking about "Can I try this again?" and just because you have tried something once and it has failed, doesn't stop you trying to again, so it's about trying to exhaust that tactic, or it might just be that that person isn't being successful with it and somebody else could be, because we all have different personality styles, traits, people will respond differently to different officers as well, so

just because one officer has tried a tactic that hasn't worked, doesn't mean to say that nobody else should try it.

Q. So, either one reasonable officer could try things more than once --

A. Yes.

Q. -- or a separate officer who is at the scene could also try?

A. Yes, and that's part of the teamwork, that if there's more than one person involved in an incident, as part of a team you can take turns. The key thing is that only one person acts as the contact at any point, so that you don't have multiple people trying to talk to the person at the same time, because that's just going to cause more stimulation and could then cause the person to be more disorientated than they initially were.

Q. So would a reasonable officer, perhaps who arrived at the scene a short time after initial officers, would they say "Well, I couldn't do anything because those other officers had adopted a particular approach"? Is that --

A. No, you have still got the option. Any officer arriving at the scene still has to decide for them what options are appropriate, so just because another officer is using force or not using force doesn't mean a new

officer coming on the scene has to conduct the same method that that person is doing.

Q. Thank you. We heard evidence from Mr Graves and I would like to ask you if you agree with some of his comments.

A. Okay.

Q. He said that a reason -- in relation to what a reasonable officer would be doing and thinking, you would start thinking -- you would be happy that -- you would have to be happy that you had hit the target:

"You [would] start thinking then: is this person 1 of 10 that isn't responsive, or is it something else like intoxication, drug intoxication, or some sort of mental health episode that's preventing this individual from showing any signs of irritant or of -- effect from those sprays."

A. Yes, with the sprays, yes.

Q. You agree with that?

A. Yes.

Q. And he indicated that the reasonable officer would:

"... now be starting thinking that this person is suffering from some form of ... disorder, we're not sure what, but I would certainly be now thinking that at this point everything's not well and we need to try and deal with this individual.

"... at some point when it is practical I am going

to summon medical assistance."

Would you agree with that?

A. Yes.

Q. So, moving on, as the subject walks away from the officers, two other officers arrive at the scene. One of them observes the scene and believes that at least one of his colleagues has been slashed by the subject and may be injured. Now, if you can assume for my purposes for the moment that that's a genuine belief --

A. Yes.

Q. -- how would -- what sort of impact would that have on a reasonable officer who had that genuine belief?

A. Okay, well, preservation of life is the top priority for all police attending all incidents, so if you think that one of your colleagues has been slashed with a knife then your priority is going to be that officer, to make sure, is it a life and death level? They're going to need an ambulance whether it's minor or major, so straight off you're going to be needing to be checking on your officer, whether that's physically running over to them or calling over to them while still trying to contain the subject, but you would be on the radio as well shouting "Officer down, ambulance required".

Q. Right. Thank you. For that officer, how would they categorise the offender behaviour? We've got the --

A. Yes, so if you believe a colleague has been slashed, that's level 6.
Q. Level 6. Why do you say that?
A. Because we're talking now about serious aggravated assault on a person.
Q. And at 4.6, can we actually see level 6 on the screen? So it will be going back up the page.
(Pause).
We can come back to that in a moment.
A. Okay.
Q. And then, if the officer has considered that to be level 6, "serious aggravated assaultive behaviour", what would a reasonable officer's response be to that behaviour?
A. Well, you want to make sure -- you mean excluding now your colleague?
Q. Assuming that the officer has arrived at scene, has a genuine belief that the colleague has been slashed, categorises the subject's behaviour as level 6; what options are open to that officer?
A. Okay. So, options would include, from the lowest end, allowing -- depending on the numbers of staff now available, even allowing the subject to flee the scene whilst you administer life-saving response to your colleague, or you have still got to think about -- if you're going to deal with the subject, you have still

got to think about your own safety as well because if they have stabbed -- if you think they have stabbed a colleague you have also then got to be thinking "They could stab me", so they need to be thinking about how can they try and bring this to a safe resolution for all people involved. So again, it would be the basics of "Can tactical communications work?" So, for tactical communications now it might be more directive as in, you know, "Drop the knife, get down on the floor", so it might be more -- it might be more dominant than the TLC aspect at the start, but you would still try the tactical communications, you would still try for the person to give up without having to get into close quarter combat with a person, so if the person can either, you know, discard the knife so that you can see that the knife is discarded and they can lie on the floor, or kneel on the floor and get their hands on their head, then again you don't want to be going into a person whom you don't know whether they're armed or not and if you believe they have already slashed a colleague.

Q. So, even with a genuine belief that their colleague had been slashed, would a reasonable officer still bear in mind the preclusion principle --

A. Yes.

Q. -- and the minimum force principle?
A. Yes. It just means you've got the options now to go up that higher, but that doesn't mean to say you discount all of the others. You're still going to try and bring it to a peaceful resolution for everyone concerned.
Q. And the example that you told us yesterday about the person who had been stabbed and was lying in the building, the flat, and the subject present, is that a similar situation where it would appear the subject's behaviour, I think, was level 6?
A. Yes, because at that point we believed he had stabbed that person, so even though we believed that he had -- we were looking at to arrest him for suspicion of murder, we still kept that distance and tried to bring it to a peaceful resolution, yet still prioritised the preservation of life of the victim as well.
Q. So those lesser forceful options remain open to officers?
A. Yes, yes.
Q. And what sort of information, at this stage -- you have said the reasonable officer would be on the radio. What information would be shared with ACR, by the officer?
A. So here you've got the issues of the officer down aspect wanting the ambulance and you're also wanting an ambulance for the subject because of the volume of risk

factors as well, so at this point you're needing two ambulances to attend and you're also calling for -- in relation to -- if you think your officer has been stabbed you're going to be saying the "Officer down, stabbed" because you want additional resources. You want to avoid having to go hands-on into that close quarter combat with a person who you think has already stabbed a colleague and might still be armed because it's demonstrating, in your mind, that they've got the means and the intention to do that level of harm.

So again, this would be additional evidence for tactical commanders to instruct officers even to back off and withdraw, or saying, you know, "Hold the line, the ARV or the dog is like 30 seconds away".

Q. Right. Would a reasonable officer in that situation, where he believes his colleague has been slashed, still be observing the subject and still looking to identify warning signs of intoxication, mental health crisis or ABD?

A. Definitely, yes, because all of that would be relevant for the investigative phase as well, because then you've got the aspect of, if there's a -- now an attempt murder investigation against a person for trying to kill an officer, or grievous bodily harm against the officer, you're still then looking for the investigation side of

proof of capacity, intent, so you're still looking for all of the evidence gathering as well and thinking about the safety of the subject as well because that person would still need to go, for example, to hospital to be dealt with before then going to the custody unit.

Q. And would that response be different if the officer is towards the end of their probationary period?

A. Certainly length of service can impact people's performance and sometimes it's -- sometimes the younger the service means they've got the most current training at the forefront of the mind, whereas the longer service, you have come through many different changes in guidance, so the current guidance might not be the most dominant in the mind, but it's also about backgrounds of each officer's experience, day-to-day, but also experience through training, different roles that they might have performed, so there's no hard-and-fast saying because somebody has got more service than another, that they're more or less competent than the other.

Q. Right. So again it will depend on their own personal circumstances as well?

A. Yes, yes.

Q. I would like to ask you again, at this moment in time, to what extent would a reasonable officer consider pulling back or withdrawing?

A. It would definitely be a tactical option because now if you're seeing -- or you're thinking that a colleague has been stabbed, your priority needs to be preservation of life, so you might then want to pull back and think "I will deal with the colleague", let the person either go if they're going, but you're defending now your colleague, knowing then that the person can be pursued by police dog, ARV teams, and one of the other benefits of not then following at times is for the track for the dog, because the dog will follow scent, so if you've got other people on the same path and officers putting their scent onto the scene as well, that can sometimes cause problems for the dog, so a clear scent path for the dog is often beneficial. So if the officers remain, let the person go, then the dog can be sent after them. It's all about that level of risk and that's what a commander then would make a decision on thinking about, do they continue to put more officers at risk because if you have already got one officer potentially stabbed, are they then going to continue sending unarmed officers after a person who has already shown intent to cause, like, deadly harm.

Q. So even if the commander or the supervisor isn't at the scene, is that one of the benefits of communicating on the radio --

A. Yes, yes.
Q. -- that those decisions can still be made?
A. Yes, yes, because the idea of the supervision levels is to think about the safety -- the overall safety and looking at competing demands in relation to different safety and different tactical options, so they might then instantly say, for the unarmed officers, because they're low in numbers, they have not got the equipment that's ideal, they could direct them to back off and not pursue.
Q. Thank you. And again, even in that situation, would a reasonable officer try and observe the principle of preclusion?
A. Yes.
Q. And adopt the minimum level of force required?
A. Yes.
Q. And in relation to Martin Graves' evidence, I would like to see whether you agree with this. He indicated this situation would:

"... cement to [the] officer that the weapon [was] present ... They [had] carried out..."

He took the view that they would have viewed it as carrying out...

"... [a] serious assaultative behaviour on another officer, who ... [could] to some degree ... [have had]

life-threatening injuries ... you are including all of this in the mix [in] the level of threat ... you are considering what you may have to do to prevent further injuries to that individual or ... to yourself or your colleague who you've arrived with.

And:

"... at that point a reasonable officer may well be considering basically any option that's open to them to deal with that particular situation, and that would include possibly causing serious injury or possibly fatal injury."

A. Yes.

Q. And do you agree with that --

A. Yes.

Q. -- that any option is open to them?

A. Yes, through preclusion, yes.

Q. Thank you. So moving on, if the subject then chases an officer, so officers have perhaps mirrored the walking away, but then the subject chases an officer, a female officer, as she withdraws and strikes that female officer to the back of the head --

A. Yes.

Q. -- which then causes her to fall forwards onto the ground and, thinking again of the categories, if we can look at 4.6, there we are, and if we can go towards the

bottom there. This, again, profiled offender behaviour. How would a reasonable officer categorise that behaviour?

A. Level 6.

Q. Right. And why is that?

A. Because the head is a "red area". So, officers are trained in relation to body code colours of red, amber and green. I know Police Scotland just use the red and green, but the head, throughout the UK, is a red colour and it's the highest risk of the red areas as well. So red means dead or serious disability risk. The head area is a specific mention for safer custody as well in relation to high risk and any impact to the head can cause internal bleeding to the brain. Then, as the person -- if they're knocked to the ground, again you can get a second impact injury from that fall. In addition to the second impact, you have also got the shake of the brain during the impact, so potentially you can have multiple injuries to the brain from that one punch and we -- you know, we often hear about "One punch kills", so then when you're thinking about the demographics of people as well, if the person who has given the punch is to a much smaller person as well, then the impact could be more significant to that person than if they were of significant, like, body size

demographics, but certainly I would consider that a level 6.

Q. And if we could have level 6 on the screen please just for a moment, so if we go down the page, there we are. That's a "Serious/aggravated assaultive resistance" that's the highest level --

A. Yes.

Q. -- of offender behaviour?

A. Yes.

Q. Thank you very much. And if that is the subject's categorisation, how would a reasonable officer categorise the level of response?

A. Then again, you've got all the options up to level 5 with preclusion, thinking about what's the lowest level that you can deal with this, so the officer's going to be looking at defence of their colleague by the best means possible, but also defence of themselves whilst still trying to achieve a safe detention of the subject.

Q. So let's look at 4.7, level 6 -- 4.7, which is the --

A. Level 5, officer response.

Q. Sorry, level 5. If we can go into the 4.7 section please. That's it. It's at the very bottom of the page now, thank you. So this is the reasonable officer's response to the subject's behaviour and it would be level 5 "Deadly or lethal force"?

A. Yes, up to that, yes.
Q. So, they don't have to -- a reasonable officer doesn't necessarily have to go straight to that, they can still bear in mind preclusion, minimum force --
A. Yes.
Q. -- and look at any option underneath that level?
A. Yes.
Q. Thank you. And again, is this information that they are putting into their National Decision-Making Model and their risk assessment and assessing the threat?
A. Definitely, yes.
Q. And are they continuing to consider their observations of the subject, considering issues of mental health, intoxication, ABD?
A. Definitely, yes.
Q. And at this stage, to what extent would a reasonable officer consider pulling back or withdrawing?
A. Well, again you definitely need to be calling to control "Second officer down, ambulance required for this person now, as well", and again hoping that they receive additional instruction from the command structure because now if the command structure are aware of potentially one officer slashed, one officer now down through a head punch, decisions need to be made from a tactical level. The preservation of two officers'

lives and safety and you've got this other officer. Do you continue to put them in a position of danger when again, the option could be all officers withdraw, allow the subject to leave and the subject then will be pursued by specialist forces, or specialist officers rather.

Q. And if the officer who witnesses this does not contact the ACR, is it still open to other reasonable officers in the area to contact the ACR and share information with them?

A. Yes. Anyone who has got the information to pass it because we need -- we need that command -- the feeding back to the command structure so that they can make their decisions.

Q. And we have heard some evidence about the use of an emergency button on the radio and again, is it open to any officer to hit the emergency button --

A. Yes.

Q. -- and that would alert the ACR?

A. Yes. Any officer can press that button and then it stays live for a quantity of time, but it doesn't stop the control still being able to speak over it, but it allows then -- for the button to be pressed for the environment to be heard, so if an officer can't physically deal with holding the mic button in to keep

talking, the quickest way is: press the red button, they can continue dealing with the high risk event that they're dealing with, but then other officers can hear the commotion or the words that are going on and plus pressing of the red button, it's not, you know, a daily occurrence for officers, it's usually reserved for those high risk incidents.

Q. Right, thank you. And I think you mentioned that yesterday as well.

A. Mm-hm.

Q. If the subject stamps -- maybe once, maybe more than once -- on the female officer as she is on the ground, how would a reasonable officer categorise that behaviour?

A. So again, that would be at level 6, potentially deadly force, and that's because of the spinal cord. The spinal cord is a red area as well and no matter where the foot might go on the body, you could still get trauma impact into the spinal cord, which is then directly connected to the brain and part of the brain, so any force to the spinal cord can cause disability or death, but then you've got your other vital organs nearby as well, such as your spleen, your kidneys and ...

Q. So regardless of whether it's on the back, lower back,

or in the kidney area, or any other area on the back, that would still be --

A. Yes, it would still be considered like, potentially, deadly force.

Q. Right. And again, if a reasonable officer is observing that, up to what level of response would be possible for that reasonable officer?

A. And again, the officer would have available up to level 5 for them.

Q. And again, maintaining the observance of the --

A. Yes.

Q. -- the principles and the minimum force?

A. Yes.

Q. Thank you. So would that -- just to be specific, would that include the option of -- in those circumstances, the option of striking the subject with a baton?

A. Yes.

Q. On multiple occasions?

A. If need be, but each strike would need to be --

Q. Justified?

A. Justified, yes.

Q. And could that include a strike, or more than one strike, to the head?

A. It could. However, the caveat with any head strikes, it's the final -- it's the final level because of the

increased risk to that, so the baton strikes -- the green areas are the primary target areas, so such as the arms and the legs. Then red areas for Police Scotland includes all of the torso and the head, whereas in England and Wales the torso is split between amber and red. But certainly the head would be a red area, but it's not encouraged as a primary strike area. That's sort of your final option because of the high risk of death that's associated with it.

Q. Right. And if the first baton strike to the head causes the subject to stop stamping, what would a reasonable officer do in that situation?

A. So, you would instantly need to disclose to the control room that you have struck the subject, a baton strike to the head, "Ambulance required for this person now as well", even if they're still on their feet and active a baton strike to the head, because it's a red area and the highest risk strike area, you need to get medical attention for that person as soon as possible as well.

Q. So when you say "instantly", even as the person is -- the subject or the officer is standing up still, in the moment --

A. Yes, if it's possible to, yes. If it's possible to make that -- so it's as soon as practicable that the officer can report this fact now as well.

Q. Right. And would it make any difference to that answer if the officer is a probationer towards the end of their probation period?
A. No.
Q. No. And again, would the reasonable officer have to provide justification for each of those strikes?
A. Yes.
Q. And would that be strikes whether they were to the head or perhaps to other areas on the arm or body?
A. Yes, because you still need to justify what target area you were going for, why you were going for it and then if you missed the target area, where it actually hit.
Q. And you have said that the head is not encouraged as a primary area, more as a final area.
A. It's final, yes.
Q. So, would it be an option open to a reasonable officer to perhaps strike the -- use their baton, but strike the subject who is stamping at the back of their knees, or on their legs, or something along those lines?
A. Definitely and when you're thinking about target areas you're constantly thinking about maximum impact, but with lowest level of risk, because you want the person -- especially if there's -- if they're in a continuation of attack, you want that attack to stop, but you want it to stop as safe as possible for everyone

involved, so you will typically try less dangerous areas before you escalate to more serious areas.

Q. And would the options open to a reasonable officer -- if they observe the man stamping, the subject stamping on the officer, would that also include the option of shoulder-charging them to the ground --

A. Yes.

Q. -- away from the officer --

A. Yes.

Q. -- on the ground?

For you personally, do you see any difference, or any distinction, between your views about the profiled offender behaviour if there is only the strike to the back of the head, compared to if there's a strike to the back of the head and a stamp?

A. No. If there's the stamp -- the head strike alone would be level 6. If the stamps also occur, that's just a continuation and a reinforcement of a continuation of such behaviour.

Q. Right, so continuation of the most serious level --

A. Yes.

Q. -- of the profiled offender behaviour?

A. Yes.

Q. And do you consider there's any difference, or distinction, in the reasonable officer response options

that are open to a reasonable officer, whether it's only a punch or a strike to the back of the head, or it is the strike to the back of the head plus the stamp?

A. I think the reasonable officer, even if there was a continuation of behaviour, they would still be -- they would still be considering where they're hitting and the risk, so they're still going through the NDM of thinking "What information am I receiving? What are the risks and the threats?" So all of that would then be taken into consideration before they make their action plan then as to what -- so it would be very much an individual decision based on the continuation of behaviour, their risk, their own -- back to that POP model of "person, object, place". So "person", if they're then thinking "Well, two people are now out of the game injured", they're the last person standing, that will impact then on what level of response they're going to opt for, because they might then believe that they're -- that the intention and the means is there to harm them.

Q. Thank you. And you have listened to Martin Graves' evidence.

A. Yes.

Q. Do you see a distinction between his views on this matter and yours?

A. No.
Q. No. So, if he has suggested that perhaps the punch to -- the strike to the back of the head is maybe of less significance than the stamp or otherwise ...?
A. I wouldn't agree that the head strike is of less significance. If anything, because of my background, I would be saying the head injury is more, or at least equal to, the back stamp, but neither is less than the other.
Q. Right. It will be a matter for the Chair. It may be that he has been saying, you would be looking at a minimum of 4, a level 5, "assaultive behaviour", you could be looking at a level 6, so he -- his evidence may be interpreted that he is more variable on the subject's behaviour category.
A. I -- yes, yes.
Q. But if that is his evidence, as it is interpreted, you would maintain that you think it's still the highest level.
A. Yes, especially when you're looking at the demographics and if the force is such that it takes somebody off their feet, then that, for me, is demonstrating that additional aggravation to it and risk to the person who -- the force has been such that it has taken the person off their feet and to the floor.

Q. Thank you.

Could you give me one second please.

A. Yes.

(Pause).

Q. Thank you. I was just checking something there. I don't need to change anything.

If -- we have also heard other evidence from Martin Graves in relation to the situation where there was the strike to the back of the head, plus the stamp, and his view was that:

"... stamping on an unprotected officer on the floor ... shows a level of ongoing serious assaultive behaviour."

A. Yes.

Q. "The risk to an unprotected officer on the floor being stamped or kicked is very serious, internal injuries, et cetera, head injuries, so we're looking at possibly life-threatening injuries in that situation ... If that was the case, and an officer was being stamped on the floor, then I would expect a reasonable officer to do anything within their capabilities to prevent that from happening or to stop it from reoccurring."

And you would agree with that?

A. Yes, with the issue of preclusion.

Q. Preclusion and minimum force.

A. Yes.
Q. And so a reasonable officer response, in relation to the stamping and the strike to the head, that would be a level -- and he agreed, that would be a level 5?
A. Yes.
Q. Thank you. I would like to move on to the next phase where the subject has been brought to the ground, but the subject continues to struggle.

I'm conscious of the time and --

LORD BRACADALE: Perhaps we should stick to the timetable and have a break at this point, so 20-minute break.
MS GRAHAME: Thank you.
(11.23 am)

(Short Break)

(11.47 am)
LORD BRACADALE: Ms Grahame.
MS GRAHAME: Ms Caffrey, I would like to move on now to deal with another situation, so to add further information into this scenario we're exploring.

So at this stage the subject has been brought to the ground.
A. Yes.
Q. Officers are trying to gain control of the subject and trying to restrain the subject and the subject continues to struggle against their attempts.

A. Mm-hm.
Q. Before I begin by asking you questions, I wonder if you can help the Chair understand how a restraint should be performed, or how reasonable officers will carry out a restraint procedure.
A. Okay.
Q. And I would like to do it first of all if there are three officers available and secondly, we can look at if there are four or more officers available.
A. Okay.
Q. Would you be happy to go through that with me?
A. Yes, absolutely.
Q. So let's look at how reasonable officers would conduct a restraint of a subject where there are three of them.
A. Yes. So the first principle is a restraint is always a combination of a use of force and a manual handling process, so you're trying to combine both of these. With three people, one person will instantly take the role of what's often called a controller, which sometimes doubles up with the supervisor as well, but a person needs to take control as soon as possible when a restraint starts and that's so that they can coordinate the restraint techniques and the manual handling process, otherwise it all becomes counter-productive if each officer is trying to do their

own thing, so --

Q. Now, if -- can I pause you there for a moment.

A. Yes.

Q. If there are three constables, so the sergeant has not yet arrived at the scene --

A. Yes.

Q. -- how do the officers go about identifying who the controller would be?

A. So usually the head person is the controller, or if --

Q. When you say "the head person", what do you mean?

A. So usually the primary objective is the two arms, so you've got an officer on each arm, and then the third person who hasn't got the arm will hopefully be in charge of the head, as in the head person is there responsible for the safety as well, so as soon as a restraint commences, then as soon thereafter the medical checks by the officers need to be commenced, so there's constantly safety checks going on throughout the process of the restraint.

Q. Right, so we have heard some evidence of the name of a safety officer.

A. Yes.

Q. Would that be akin to the person --

A. Yes.

Q. -- in charge of the head?

A. Yes, so there's three roles which are typically specified: we've got a controller, a safety officer and a supervisor. Now, in an ideal world you've got a different person doing each role, but often you have to have those all combined into one person, but they're the three roles. The controller is the person who is directing in relation to the manual handling and the technique. The safety officer role is to be conducting the checks, the vital signs, and then the supervisor is the umbrella overall supervision of what's happening, but typically, especially in the early days if you have only got a small number of officers, all of those functions need to be conducted by one person.

Q. And that's usually the person at the head?

A. Yes.

Q. Thank you.

A. So with three people, if the person is on the floor, the primary objective is one person on each arm to get the arms behind the back and handcuffed, and the third person -- if it's safe for them to be at the head, they're at the head, but if there's a lot of issues in relation to securing the legs, then that person might need to go to the legs as the third person, in which case then one of the arm people need to be declared as the controller and safety officer.

Q. And how are they declared?
A. It's constant talking to each other and the person being nominated or instantly saying, "I am the controller in this use of force", and that might seem a bit sort of false, but it happens regularly that as soon as an intervention starts and a restraint starts, somebody calls up "I am the controller", you know, "I am on the right arm", "I am" -- so that you can hear who is doing what and then you know if a certain act is being conducted.
Q. And to what extent is there communication between the officers during this process?
A. All the time. The more communication between the officers and in a calm manner, the more then the officers know what's happening, who is doing what, what responsibilities are being conducted, but also it can help the person who is being restrained to understand what's happening. Otherwise if people aren't talking and there's just a lot of movement going on, the restrained person can be put in an even more heightened state of distress because they don't know what's happening.
Q. Right, so if an officer is, say, on the legs, what would you expect that reasonable officer to be doing if they're facing the other direction from the officers?

A. If that officer is facing the other direction, if they can face up the body, fine, but if they're facing away from the torso, because of the communication they're still all talking to one another, so if they get their arms tucked around the legs they will then say, like, "Legs are secure", and whoever is the controller will say, you know, like, "received" or "roger that", you know, "right arm secure", "left arm secure", so people should be constantly talking through what's happening so that there's no dispute in relation to who is doing what and if it's happened or not.

Q. And if they're engaged in that process how do they then go about securing the subject? Do they use equipment?

A. Yes, so it's the handcuffs to the hands which ideally -- the ideal position is to handcuff to the rear for maximum control but sometimes it ends up at the front, but rear handcuffing is the primary objective but sometimes it will end up being at the front, so once the arms are secure -- if the officers then believe that they've got more control over the subject than the subject has got over them, they might then deem that the person is secured purely with the handcuffs and no necessity for the legs, or if the level is such that they also need to do the legs with the straps, they might then do the handcuffs and the legs before

announcing "secured", but the phrase "secured" implies that the officers believe they've got more control over the person than the person has, so there's no chance of them escaping.

Q. So if there is a message to ACR saying "Male secure on ground", does that mean something to police officers?

A. That would mean that they've got sufficient control to prevent the person escaping or assaulting them.

Q. Right. And what if the officers experience difficulty in getting the man or the subject's arms behind his back and getting those handcuffs on?

A. So there's options. I mean, you can even do chain-linking of handcuffs, so I know a particular example that I had was we ended up using the three sets of handcuffs to join, so one officer put their cuff to the right-hand, one to the left hand, then with the handcuffs they were used to get the hands behind and then my cuffs went as the joining cuffs to those two cuffs, just to get the initial control so that then as time went on, we could then release the cuffs and make them smaller, but sometimes with large men, for example, body builders, because of the size of the chest it's near on impossible to actually manage just with one set of cuffs and you might need to link two sets to them.

Q. In what circumstances would you not handcuff to the rear

but handcuff to the front?

A. Maximum control is to the rear. If the person's handcuffed to the front it means then they have still got movement with the hands, they can still attack somebody, they have still got control over the body dynamics. When you put the handcuffs to the rear it also affects the balance of the person as well, so it can reduce the amount of resistance, but things like shoulder injuries, those kind of scenarios, it might be that person's arm doesn't bend so if a person has injuries already existent, or any physical disability, it might not be practicable to get their arm to the back anyway.

Q. Right. What position would the subject be in during what you have described?

A. So officers are typically trained to get the person initially into prone --

Q. On their front?

A. Onto the front, yes, sorry. Onto the front, in prone, so that the arms can be brought to the rear and handcuffed, depending then on whether their legs are going to be strapped. But then as soon as the person is secured, the person then needs to be turned onto one side or the other.

Q. Right. Now, you have in your report a description of

your understanding of prone. Are you able to just share that briefly with the Chair?

A. Yes, so the basic prone is the person is laid fully on their front, but there's variations of prone as well and I know in the past, myths where it was only prone if the face was actually looking at the floor and people used to think well, if they just turn their head to the side that meant they weren't in prone, but prone is just meaning that the front of the body -- so basically from the belly button up until the head area is towards the ground. That means that the person is either in full prone or partial prone, so it might be that you've got the person on their front but they've got their torso lifted up so there's just part of the torso to the floor, that then would be a partial prone.

Q. And if the subject has perhaps tried to lift one shoulder from the ground, would that be a partial prone?

A. Yes, it's still a prone, partial prone.

Q. Partial prone. Would a partial prone be treated in the same way as a full prone by officers?

A. Yes, yes, it should be because the main thing about the positioning is about then whether it impacts on breathing functions and so even just with one shoulder off we have still got potential of compression of the like diaphragm area and the stomach, and even if it's

just the bottom of the stomach, if people then have got excess weight or pregnancy weight, that weight can be pushed up and into the diaphragm and prevent the breathing function occurring.

Q. So what advice are officers given about the prone position?

A. That because of its high risk you get the person out of it as quickly as possible, you get them secured, you get them onto the side, so the person might not be safe enough to get up into seated or standing, but they're secure enough to get into a side position.

Q. And when you say high risk, is that because of the impact -- possible impact on the breathing?

A. Yes.

Q. Right. We have heard some evidence about positional asphyxia.

A. Yes.

Q. Can you tell us about that?

A. Yes, so if we're thinking about positional asphyxia it's all about a position which impacts the breathing capability, so if we've got the front of a chest and the back of the chest, two sides, there's four parts of the body from the waist up which needs to be able to function in order for breathing efficiency.

Now, if you compress either the back or the front in

any way, that means that one side doesn't move, but likewise, even bent forward in a seated position because now you have compressed the stomach, that can impact as well, so that's a position which can start leading to asphyxiation, so the asphyxiation is just connected to a position. The person could be on their side which would in itself be deemed a safe position, but then if pressure is lent up against the person to then impede the function of the front or the back expanding, that would still be a position which is now impeding the breathing, which could lead to asphyxia.

Q. So to what extent would simply lying on the pavement say, in full or partial prone, compress breathing?

A. It would depend then because if you've got any pressure -- in order for the breathing function to work, you need everything from, you know, the very bottom of the diaphragm to be able to function correctly, so if there's any pressure going into the diaphragm, that will impact, but then the muscles within the chest and shoulder as well, they need to be without compression in order to allow the lungs to inflate and deflate, so it would depend on where the pressure is as to -- and then the body weight of the person, because if the body weight then is pressing in as well, their own body weight, even if no officer is pressing against the

person, if there's stomach weight there that's pressing in and hanging in, then that can cause some compression as well.

Q. And then if one was to apply any pressure to the back at the same time, would that again compound the possible --

A. Yes.

Q. -- impact on breathing?

A. Yes, because it's impacting on the back's function to expand and contract as well, so it's like a bellow, you know, at a fire, you need the body to be able to expand and contract in order to create the efficiency of the breathing to happen.

Q. And when you talk about pressure, what type of things are you talking about?

A. Even just leaning up against the person could be creating pressure. It's something that's stopping the full expansion of the torso.

Q. And could that also include putting weight on a person?

A. Yes.

Q. Applying force to a person?

A. Yes.

Q. And could that be in one area or over the whole back area?

A. It could be any part of the torso, so again from anywhere from like the belly button up, any part of

pressure against any part of the torso could create an impact.

Q. We have heard some evidence that sprays can also have an impact on the respiratory system.

A. Yes, yes. So because of the nature of the spray and a person's response to it, it can impact on the breathing capability.

Q. And as well as that, if the subject is intoxicated or under the influence of drink or drugs, could that also have an impact on the respiratory --

A. Yes, that all affects the breathing capability as well.

Q. And is this something that officers are aware of in terms of training about positional asphyxia?

A. Yes, definitely.

Q. You have told us earlier you're a first aid trainer --

A. Yes.

Q. -- and you have taught many courses. Is this the type of information that officers are provided with?

A. Yes.

Q. Thank you. Can I ask now if this process is done by more than three officers, so four or perhaps more officers, can you explain to us how that changes this type of --

A. Yes, so if we're looking now at a fourth officer, you've got one officer on one arm, one officer on another arm,

officer number 3 is on the legs, officer number 4 is the head officer, so that may or may not need any actual touching of the head, but that head officer is the person who can look right down the torso and ensure that there's no compression, so they're the safety officer. They're also the controller coordinating the officers and they might then be saying to the leg officer, for example: can you move lower or higher, so if you know their names you can be using the names of the officers, but it's about that clear instruction so that the other three officers, even if they're not actually looking in at one another, they know exactly who is doing what.

Q. So again, still communication required?

A. Yes, absolutely, and controlling what's occurring so you might then say "The officer on the left arm, you're going to apply the cuff first", so that you will -- the officer on the right arm stays in a holding position of the arm, a physical holding, until the officer has got the cuff on the left arm first, so you want it to be coordinated, controlled and a nice, easy process so that it all just happens nice and smooth.

Q. And again, if the officers are communicating, would that then allow the subject to -- or the possible opportunity for the subject to understand what's happening?

A. Yes, and often, you know, you're -- depending on the

circumstances you can be talking to the subject saying "We're going to start handcuffing you now, the officer holding your left arm is going to apply a handcuff so don't be worried", so it all depends on the circumstances and is it -- are you able to speak to the subject or at least try and speak to them, to let them know what's going on to again reduce the fear and the anxiety and hopefully reduce the opposition and resistance.

Q. And again, yesterday, when you gave us the example of attending at the scene with the man with the arterial bleed, I think I commented then that you were talking to the man and telling him. Is that the type of communication you would expect during a restraint?

A. Yes, definitely, because -- the benefits are it allows you as the person doing the talking to be thinking logically about what are we doing, but it also then allows you as a team to understand what's actually happening, so you will often find officers, once they've got their lock on, they will shout, you know, "Right arm lock on", you know, "Left arm lock on", when the cuffs have gone on they will shout "Left wrist cuffed", so it is this constant talking and passing the information between the team so that you know what's happened now it's safe to move on to the next.

Q. When you say "Lock on", what does that mean?
A. So, for example, if you were taking -- there's something called a figure of 4 lock where manually you will take the arm back, so it looks like a figure of 4, so you might then say -- you know, once then you as the officer have got tucked into that, you will say "Right arm lock on", so that officer then on the left arm knows it's ready for them, so if there's a controller there they will then say, "Right arm lock on, left arm put your lock on", so then they know to turn and get the left arm lock on, and then they will say, "Left arm lock on", when they have achieved it.
Q. If we're talking about four officers, again, there's one at the head who combines the three roles of controller, safety officer and supervisor?
A. Mm-hm.
Q. But if more officers arrive, would that officer at the head, would the role be split again or --
A. So then you might have the next person coming along who takes over as supervisor, so -- who will then, you know, start doing that. It's very much -- it's a flexible option, but you take that position, so for me as the sergeant, for example, these type of controlled events would occur regularly in the custody unit, so then as the custody sergeant I would take the supervisor's role,

but the controller has started, so then I would say, you know, "I'm here now, I'm the controller" -- sorry, "I'm the supervisor, confirming you're the controller", you know, "Officer A, you're the controller", officer B, C, D, then I would be moving around to keep looking there and then saying to the controller, "Have you checked the vital signs? Confirm to me that the vital signs are still okay."

Q. So if a restraint is taking place with, say, four officers and the sergeant arrives, when that's already started --

A. Yes.

Q. -- what would you expect that sergeant to do on arrival?

A. That the sergeant comes along and takes the supervisor role so they should be thinking then about all the issues around the holistic safety, so thinking about the safer custody aspect and the NDM again and thinking is this person going to police custody unit or are they going to hospital? Have we got an ambulance en route? Do we need an ambulance en route? And then asking the officers, you know, "What are you doing? Is that lock on? Is that" -- so getting involved as a supervisor and making those, like, management decisions.

Q. So an active role?

A. Yes, and checking what decisions have been made and

confirming -- "Can you confirm the vital signs have started?" You know, which are your DR ABC checks that you're looking at so it is about the supervisor taking that overview and thinking: you're doing that, you're doing that, do they need additional people, is an officer injured, because if you've got an injured officer on a particular limb you might want to swap them out for somebody else and then looking at how long has this been going on, you know. In an ideal world, you would instantly start clocking the time as well to be thinking how long has this been happening now, where are we at time-wise because that would be relevant for the -- as a handover to the ambulance crews as well.

Q. And why would the controller be or supervisor be saying "Where are we with the time?" Why is that relevant?

A. It would become relevant for clinical management at the hospital. It may or may not end up being relevant, but where possible, you always start clocking the time to think where each stage has taken us, how long was the ground restraint for.

Now, there is no mandate as to how long a restraint lasts for, but it's also -- it should always be as short as possible.

Now, in the past there's often been debate about whether a time limit should be set as a warning mark and

I know from a previous death in custody back in 1999 the inquiry into the death of Mr Bennett, they recommended at that one about restraints -- 3 minutes was the warning time, but that's not a mandate, but time could be relevant as part of the handover package for the clinical care really to then be saying the person has been on the floor in a side position or a prone position, resisting for, you know, three minutes, five minutes, ten minutes, before we were able to get them into seated position and then from seated position as we got them up into standing they then collapsed at that point, so it's just -- it's relevant information for the clinical care of a person.

Q. And could it also be relevant information with justifying that minimum force has been applied?

A. Yes.

Q. Or could it be relevant information in relation to issues surrounding positional asphyxiation?

A. Yes.

Q. And concern to avoid asphyxiation, particularly if the person is in prone or partial prone?

A. Yes, definitely, and the supervisor might then decide that because of the time ticking on they want to ensure that the person -- you know, are they going to try and manoeuvre into seated and standing because of the time

issue and -- but again, it would be that decision on the day, thinking about the NDM and thinking "Are we in a position where we can attempt to get the person out off the floor", even though they're out of prone or supine, supine being on your back, they've been on their side but there comes a point where when we need to now try and get them into seated position, or the level of consciousness, are we waiting on the ambulance. So it's about those decisions and thinking "How long are we waiting? Is this still a straightforward use of force restraint, or are we in a medical emergency?"

So time can be relevant but it's not a topic just on its own.

Q. And officers are still considering the possibility of a medical emergency --

A. Yes.

Q. -- even during that process?

A. Yes.

Q. And moving someone onto their side or into a seated position, does that also remove the pressure if they were lying on the pavement?

A. Well, it can remove the direct pressure, for example, to the front if they were in the front or on their back, but if officers then go close, we have still got compression into the stomach or the back, so the idea of

the side roll is as a safe airway position. You're holding the person up, but you create a little bit of gap between you and them so that they can still expand their torso in order to breathe.

Q. And so bearing in mind the risks of positional asphyxia and the risk of compression --

A. Yes.

Q. -- are officers made aware of the risks of lying next to a person, or lying on the person, or having parts of their body up against a person?

A. Yes, it's -- because it's about not having any pressure against any part of the torso, regardless of what positions they're in.

Q. Right. Thank you. And even if there are four or more officers, would they again be seeking to apply handcuffs at some stage?

A. Yes, because in order to get the person from the ground restraint you're going to look at handcuffs. The option then of leg restraints, depending on the circumstances, but then getting the person into a seated position as soon as possible and getting them stood up as soon as possible, so that's always the objective. So even if they could be stood up with leg restraints and handcuffs still applied, but we've got them off the ground now from a ground restraint.

Q. We heard from Martin Graves that he would recognise that there's a control phase of restraint where officers are attempting to control the subject and he would distinguish that from the restraint phase where the person is restrained.

A. Mm-hm.

Q. Is that a distinction you would recognise?

A. Yes. I mean, the initial bit is obtaining control, so once you've got the handcuffs on then typically you've got the basics of control then and you're into the restraint. The restraint then is -- you know, the person can still be moving and -- you don't have to wait for a person to be passive, fully passive before you consider moving them into a seated and standing position.

Once you've got control of them, even if they're trying to physically resist, if they're handcuffed and their legs are restrained, there's nowhere they can go, they can't run and they can't assault people, so it's about trying to get them up. The officers are then still holding their arms, so there's -- it's the safer way to get them off the ground.

Q. And that moment arrives when handcuffs are fixed to the wrists?

A. Typically, yes. You've got the person under control

enough to be able to manage them.

Q. Right. I understand from your report that there are different types of restraint, not all restraint is physical?

A. Correct, yes.

Q. Do you --

A. So -- well, you've got the physical restraint. You have also got, like, chemical restraint, which is more common in the mental health units where the person will be injected with something and often the police are called to mental health units to assist with -- so officers might be doing a physical restraint in order for the medical staff to inject for a chemical restraint.

You have also got, like, psychological restraint where the person is kept in a room but the person is at the door, so there's no physical restraint on the person, but the mere presence of an officer standing at the only exit is still restraining and containing a person within a room.

Q. Thank you. I would like to ask you about the options for a reasonable officer -- to go back to our ongoing scenario that we have been discussing yesterday and today, so it's a knife incident, possible knife, there's issues that we have discussed about the way the subject appears and there was the punch to the back of the head

and/or the possible stamp or stamps, and the subject has been brought to the ground, and the officers are trying to gain control of the subject and the subject is resisting that control, perhaps at times forcefully.

What options would be open to three officers who are taking part in that process, if they're reasonable officers?

A. If you're looking at the full spectrum of options at the very lowest end one option is withdraw from the restraint.

Q. Under what circumstances would they do that?

A. If you think it's too dangerous for staff or subject then it's still a tactical option that you can withdraw from the restraint. Once you have commenced a restraint, it doesn't mean to say you can never like get out of it.

Q. Is it always an option to disengage?

A. There's always still an option to back off and consider again other alternatives that you might have, or a fresh approach again.

Other than that, you're trying to gain the compliance, so it might be, for example, each officer at each arm applies their single cuff to the relevant arm that they're on to try and then get their arms brought round into the figure of 4 type of lock.

Q. And just to stay for a moment with the option of disengaging --
A. Yes.
Q. -- you talked about a fresh approach, could that be waiting for a dog unit to arrive or something along those lines?
A. Yes, yes.
Q. So assuming that they don't adopt the disengaging option, what other options do they have at that moment?
A. So it's still -- if you're continuing with the restraint then you need to get the restraint achieved as quickly and safely as possible and the only way to achieve that really is then by the use of the handcuffs to bring their arms in and the straps to the legs, so if there's enough officers to be trying to get them going again it's -- this is where the controller and supervisor's role is important to make those decisions, how are we going to do -- do we do one and then the other, or are we going to go for then both together? Are they going to go for the legs first -- typically it's always the handcuffing is the first option.
Q. Why is that?
A. It's just to get the upper body secured.
Q. So that would be one officer on each arm?
A. One officer on each arm.

Q. And the controller at the head?
A. Yes.
Q. And would you recognise a description of the controller's role holding the head in a position where it's secured against the ground to prevent the individual from banging their head on the floor and sustaining secondary injuries?
A. Yes, so especially the prison office, the prisons teach immediate holding of the head to secure it. The holding of the head is a taught technique within the police service but it doesn't have to be a mandatory hold. If the person isn't at risk of doing such things then you may deem it not necessary to actually hold it. You can still be the head officer without physically holding the head.
Q. And then in terms of disengagement, would you recognise the possibility that officers take the view it's impossible to restrain a person and they should consider other tactical options, or in a situation where the restraint has been attempted and failed they could disengage and then they could use things such as irritant sprays, or nowadays perhaps a taser. Do you --
A. Sorry, can you just repeat that?
Q. Sorry. So thinking about disengagement and the options open to officers in that regard --

A. Yes.
Q. -- would you recognise a description as a number of officers decide it's nearly impossible for the officers to restrain the subject and other tactical options have to be considered, and in that situation, it may be the case that where restraint has been attempted, has failed, they will disengage and then use irritant sprays or nowadays maybe use a taser?
A. Yes.
Q. You recognise that as a possibility?
A. Yes.
Q. Obviously in 2015 there wouldn't have been the tasers available with uniformed officers, but do you recognise that that would be an option to disengage --
A. Yes, definitely --
Q. -- and go back to trying sprays or --
A. Yes. If the physical restraint becomes too high a risk, either for officers or subject, then you need to consider another option.
Q. Right, thank you. So the officers can consider those other options. Assuming they're not disengaging -- we're talking about three officers, one at the head, two on the arms -- they're trying to secure handcuffs. If there's more than three officers by that stage what would those officers be considering as options?

A. So one on the legs.
Q. One on the legs as well as the two on the arms?
A. Yes.
Q. And one on the head?
A. Just to try and stabilise the person.
Q. Would the priority still be for those officers to secure the handcuffs first?
A. Yes, that would still be the first option, unless it was deemed necessary to secure the legs first, so that the leg officer can be relieved of that role and come and assist with the arms. So particularly if you've got someone that's really strong, you might then need -- you might decide secure the legs so that releases that person to come and assist with the handcuffing.
Q. And when we say secure the legs, we have heard evidence that not only can an officer lie over legs, but they have leg straps or Fast Straps?
A. Yes, Velcro straps, yes.
Q. Right. And that's a means whereby officers can secure legs?
A. Yes.
Q. In terms of the pressure that those officers involved in that process would be applying to the body, what would reasonable officers be bearing in mind at that stage?
A. All pressure to the torso should be avoided. Pressure

to the legs by the body laying over is an approved technique and pressure to the arms to secure them and bring them round is an approved technique.

There's also the knee to the back of the shoulder blade there to help with the ground pin, that's an approved technique, but other than that there should be no pressure going into the torso anywhere.

Q. And would that include on the back of the body?

A. Yes.

Q. And when you say a ground pin, can you tell us what that is?

A. So when the person is down on the ground, for example, particularly with a single officer technique you might get the person to the floor and then you've got the arm out and you're trying to bring it in to commence the handcuffing, the officers will be trained to then use one knee to go down onto the shoulder blade to facilitate the handcuffing coming in.

Q. That's a recognised technique?

A. Yes, but then as soon as you've got the cuffs applied, that knee pin would be removed.

Q. Right. But apart from the knee pin to assist with the ground pin, what would a reasonable officer be doing in relation to applying any weight or pressure on the back?

A. No pressure to the back.

Q. No pressure. Would they apply any weight, or their own body weight to the back?
A. No, no.
Q. Would they lie over the subject?
A. No. The principle is no pressure to the torso.
Q. What about contact itself, if they were leaning over or contact with the person's back?
A. It should be avoided and this is where if the head person is there, if an officer is needing to lean over, then is there already an officer on that side who can be doing that task? And then you pass the arm over to the other person. It's trying to keep like a sterile area of the person. That's the principle. There will always be exceptions to a principle, but the principle is you don't put any pressure onto that torso.
Q. Right. Does it make any difference to your evidence today if the person is on their back as opposed to on their front --
A. Not at all.
Q. -- or partially --
A. Not at all. Because the same thing, you have to have the front and the back of the body and the sides to be able to expand in order for breathing function to work, so whether the person is on their front or their back, you need to keep those areas clear as much as possible,

for as long as possible.

Q. Thank you. And you have gestured when you were describing the role of the controller, the person at the head, and you have gestured with your hands.

A. Yes, so they're looking right down the torso --

Q. From the head to the feet?

A. From the head, yes, and the benefits of all of this is to ensure that it's clear, so when I use the word like "sterile", that there's no compression, there's no officer laying over, anything going on, but also that there's an alignment of, like, the spinal cord, so if officers are trying to twist the body -- if it's not coordinated and some officers are trying to push them onto a side and others are trying to keep them on their front, then you might get a twisting, which again increases their injury risk, so that head officer as the safety officer needs to be able to keep looking down the torso and see that there's an alignment and that it's without compromise, so there's no compression anywhere.

Q. And that risk of injury is to the subject?

A. Yes.

Q. What difference would it make, if any, to the evidence you have given today if the officer -- sorry, if the subject had continued to struggle against the officers and had tried to bench press them off the subject?

A. I think the issue there -- again, it comes back to your options: you have still got the option to withdraw and think about new tactics, you have still got the option to carry on trying to get the handcuffing process done to achieve, because until a person is handcuffed to the rear, they will always have the capability -- or potential to be able to press, even if they're handcuffed to the front they have still got the opportunity to be able to put their hands down and press up, so your options there would either be still continuing to try and get the arms to the rear to use and that figure of 4 can either be done manually with the officers' arms, or there's also an approved baton technique to be able to use the baton to help get the arms around, but the majority of officers prefer to use their own limb to get in and get the arm under.

Q. And in relation to the bench pressing, is there any difference to your evidence if the subject is seeking to remove weight, or officers from his back?

A. I think for that if -- if a person is able to bench press an officer up off the floor, I would be worried there about the amount of strength they're showing to be able to do that, but also I would be worried that the officer was actually on their back in the first place as well. It's just confirming that somebody was on their

back, so then it would be trying to again, go back round to the NDM and think "Do we need to all withdraw from this and think about another tactical option, or do we carry on trying to adapt what we've got to try and secure as quickly as possible and get them out of the ground restraint?"

Q. And would it only be the controller that could make that decision, or would it be any of the officers involved?

A. Any of the officers involved could take over control. If they feel whoever is controlling is not controlling, then they need to declare -- but as a team they need to work with this as a team, and that's where at times we've got these specified roles, but that controller can then hand over control function to somebody else, so someone else might become involved who is more skilled, for example, at this kind of coordination, so they can agree to hand control over to that other person, then everyone else involved in the technique knows now they're listening to the new controller.

Q. And a moment ago when I asked you about the bench pressing --

A. Yes.

Q. -- you said you would worry about that and why would you be worried about that?

A. Just the demonstration of strength and thinking about if

it we've got other ticks of risk, is this then another tick of risk that again we need to be reporting back because this could emphasise again that we need specialist resources to deal with this. This is beyond business as usual for operational officers. Do we need the specialist resources and again, if we have not currently got an ambulance en route, is this now extra confirmation that we need an ambulance because if there's that much strength being used, this person needs to be checked by a healthcare professional before going to police custody unit, or the decision to go to hospital.

Q. When you're talking about the tick list or checklist, are these the risks you mentioned earlier: intoxication, mental health crisis or ABD?

A. Yes, yes, so it's this accumulation of more ticks coming on those lists.

Q. And for a reasonable officer that maybe isn't involved at that time in the restraint but standing and observing at a nearby location, what action might that reasonable officer have?

A. Contacting control room and passing the information back because if they're then seeing the officers are not doing it, somebody needs to be doing it, so when we think about professional responsibility and curiosity of

an event, they need to be passing that information back to the higher ranks to be saying ,"This is what we're seeing, tactical advice, please".

Q. Seeking advice from the supervisors?

A. Mm-hm.

Q. Right. What difference would it make if the subject remained non-verbal during that time, so wasn't speaking during that time?

A. Well, non-verbal is always a risk because of the fact you're thinking: well, why are they non-verbal? Is it a disability -- you know, a life-long disability that the person has got, or is it because of a medical issue, such as the -- a high level of intoxication which is preventing the person from being able to operate their vocal cords, or have we got a mental health crisis, which again, it's a medical issue.

Q. What difference would it make if the subject was making roaring noises and shouted something similar to "Get off me"?

A. So again, the basic warnings for people being unable to breathe will be saying things like, "I can't breathe", or "Get off me". Those are threaded throughout officer safety training about listening to warnings from people, to again take them into consideration because you're not going to let go of every single person who says, "Get

off me" or "I can't breathe", but you're looking then and thinking, well, if they're now triggering this I need to satisfy myself that there's nothing which is causing a risk to the person.

Q. And if we think about the techniques that a reasonable officer might be using in terms of their baton as part of this restraint process, would you -- what techniques would a reasonable officer be using?

A. It would be trying to get their arms round for the handcuffing and that -- the majority of officers will just attempt that with their arm into the subject's arms to get them round, or the use of the handcuff to act as a lever to get them round. Next level up would be trying to maybe use the baton to get the figure of 4 position, but that can be quite technical and to be honest, I have seen very few officers ever use the baton for a figure of 4 technique, because it's not really an easy option to do.

Q. Right. And what if an officer used a technique with a baton that wasn't trained?

A. So there's always the scope for techniques to be adopted and made up as the scenario goes on, but the purpose of approved techniques means that if you're conducting an approved technique, the organisation is saying: we have approved this technique and we are satisfied that it's

been medically risk assessed, and then we have listed what the safeguards are around it, so if an officer is then using a technique which is not on the approved techniques, they then have to justify to themselves the necessity to use that technique and also be conscious and aware of the risk factors with it. So you tend to find officers will try and use the techniques that are actually approved and taught, rather than deviate.

Q. Thank you. Can I come back for a moment to breathing and monitoring of breathing. We have heard evidence about breathing and not breathing and I saw in your report that there was a distinction that you drew between normal breathing and not normal breathing.

A. Yes.

Q. Could you explain the distinction for us, please?

A. Yes, so basically every five years there's a new code released by the Resuscitation Council as guidelines for all first aid training and certainly from 2005 they changed the breathing/not breathing to be breathing normal/not normal, because what they were looking at there was the decline at times in a casualty that it's not often you go from being a normal breather to not breathing, there's usually a decline.

So part of their cycle then would be early recognition that something is going wrong as the first

key stage in survival and you may see on posters these little circles attached with, like, the defibrillation at the end, but the first stage is early recognition that something's going wrong, and that's where the breathing/not breathing normal comes into it, so normal breathing, for an average adult, is two to three breaths within 10 seconds, and that sounds quite effortless and what they say then is within a maximum of 10 seconds the first aider or person who is monitoring the breathing, within a maximum of 10 seconds they need to decide if the person is breathing normally or unknown and if it's unknown, then they treat them as not breathing normal, so at that point of not breathing normal it's a medical emergency and CPR is commenced.

Q. Right. So let me just ask you this: are all first aid trainers aware of this guidance?

A. Well, if they follow the Resuscitation Council guidelines, then they should be aware of it and it's in the first aid manuals, particularly things like the St John's manual, it all refers to not breathing normally.

Q. And was that the position in 2015?

A. Yes.

Q. And when was that distinction introduced?

A. It was brought in certainly in 2005. So the guidance is

every five years, so it was in the 2005 guidance as breathing normal/not normal and then the 2010 guidance, then the 2015 guidance and now in the current guidance as well.

Q. Are you aware when the guidance is issued?

A. Every five years.

Q. So a month in a particular year?

A. I'm not sure which -- but certainly the 2010 version had the normal/not normal interpretation.

Q. And the 2005?

A. Yes.

Q. Thank you. And when that breathing is not normal, you say that's a medical emergency and CPR commences?

A. Yes.

Q. Even though the person may still be breathing to some extent?

A. Yes, because for a lot of people -- they use the phrase agonal breathing and a lot of people will still show signs of some form of noise which might sound like gas or snoring or moaning or -- there's one explanation which says about like fish mouth where the person might be going (indicating), and it looks like a fish mouth, whereas if -- with the old interpretation of breathing/not breathing, things like the fish mouth, agonal breathing, the moaning, they would be incorrectly

assumed to still be meaning the person's alive, where this person was actually in life and death scenario.

Q. Right.

A. So breathing normally, breathing not normal was certainly the version of the Resuscitation Council guidelines in 2015.

Q. Thank you. Just to finish this scenario, is it safe for me to say that a reasonable officer will, during the struggle and restraint, still be seeking to use the minimum level of force?

A. Yes.

Q. And still have regard to preclusion?

A. Yes.

Q. And moving on to if the subject is on the ground, either prone or supine, the officers are trying to gain control, the struggle has continued -- the subject has continued to struggle against their attempts and that has continued for a period of around four minutes, during which time the officers ultimately manage to secure handcuffs and leg restraints, the subject is then turned onto his side and the officers see that he is non-responsive or unconscious, but deemed to be breathing. What would a reasonable officer be considering at that stage?

A. So this is where your DR ABC comes into it all --

Q. Remind us about that?
A. So D is danger, so that's danger not just from the environment, like they're on the ground, on the road, but danger in relation to any risks posed to them from, say, officers being too close to prevent any movement. The R then for the response, there's then another acronym called AVPU, A-V-P-U, that gets taught, and the first bit is alertness, what's the level of alertness? Do they respond to voice at all? Do they respond to pain? So pain there, they're typically taught to either squeeze the shoulders or sometimes certainly the nipping of the earlobe might be considered, but then if those are showing no response, then the casualty is classed as an unresponsive casualty at that point.
Q. And what would a reasonable officer do with an unresponsive casualty?
A. So unresponsive casualty is ambulance and then a suitable safe airway position so there's -- people will often talk about the recovery position but it's about a safe airway position, so any side lateral position, so, for example, the position that officers are taught to put the person in when they're restrained anyway, on the side, as a barrel, that is still a safe airway position as long as there's no compression up against the torso, either front or back.

Q. And would compression include an officer lying at the side of the subject?
A. Yes, yes. So you want to be able to remove the weight and you can still balance the person by holding onto the, like, upper arm.
Q. As they're on their side?
A. Yes.
Q. Right?
A. So then at that point if they're deemed to be unconscious you then have the A, B and C to do. So A is the airway: is the airway open enough and no blockage because it might be that you find the person is actually suffocating, asphyxiating on an object, so if they had, for example, a ball of drugs in their mouth and that's now gone into the windpipe, so it could be an object or it could just be that the airway is impeded by, for example, the tongue or the position, so if you're sure that the airway is clear, if the person is on their back then it's a case of just you get hold of the forehead and move the forehead backwards and that then should ensure the alignment of the windpipe and that is all open.

Then it's the breathing check, so this is where you've got a maximum of 10 seconds to decide is the person a normal breather or not normal, so if there's

any doubt about that allocation, you go with not normal.

Q. And if they're not normal, what do they do?

A. Then it's C for compression/CPR, so you start the CPR. So then you would have an unresponsive casualty, not normal breathing, CPR commenced.

Q. And an officer -- a reasonable officer would also be calling for an ambulance?

A. Yes.

Q. Treating it as an emergency?

A. So you would have called for the ambulance before checking the airway, because as soon as you get to the unresponsive, that's where you're saying "Ambulance, unresponsive casualty", you carry on with your A, your B, non-breather, so then you're updating control to update the ambulance control, your unresponsive casualty is not breathing normal.

Q. And we may look at something later that uses the term "rousability" --

A. Yes.

Q. -- or "not rousable." Is that the same as responsive/not responsive?

A. Rousing is commonly talked about within -- for physically within police custody and rousing checks, so, for example, anyone who is at high risk, they need to be roused at certain time limits, so --

Q. What does that mean?
A. So that means is the person -- so on every visit you might need to mandatory rouse them, so you need to make sure that they're awake, alert, they can speak, they can hold a conversation, so they have to demonstrate physical and neurological function, so it's no good me just saying to you, "Are you okay?" and you going, "Ugh", so I need you to be able to give a few words back to form a sentence and show that you can respond, so the first time I might say to you "What is your full name and address?" The second time I might say to you "What's the address of your workplace? What is your phone number", on the next one, but a lot of people fail that one with the phone numbers.
Q. Okay.
A. So rousability is showing about even if they're physically awake, are they actually able to communicate and can understand things, so --
Q. So it's not quite the same as responsive/not responsive?
A. No.
Q. Would a reasonable officer consider slapping the subject in the face to determine if they are --
A. It's not taught within first aid or officer safety training.
Q. Right. Would a reasonable officer step back -- so as

the subject has been handcuffed and leg restrained, turned onto their side, noticed to be not responsive, but breathing, would a reasonable officer stand up, move away to a small degree for an estimated period of 30 seconds to one minute, consider excited delirium for a few seconds, and then return to have a closer examination of the subject?

A. Well, preservation of life is always the top priority for all police officers, so if you've got any doubts about the life of your casualty, then you're going to give them constant supervision, constant observation and be dealing with them as a casualty, so it would look at what is the priority of leaving the casualty. If it's because, for example, they can't get a signal, or their radio is over there so they have gone for the radio, then that would justify leaving your casualty, so it would all be looking at the prioritisation, but the basic principle is you've got a casualty, preservation of life is the priority, your casualty is constantly monitored and then you're constantly monitoring your DR ABCs and deciding on whether has breathing now changed from normal to not normal.

Q. Would a reasonable justification be checking superficial injuries on hands or --

A. No, because on the balance then of risk, the

preservation of life would take precedence over that.

Q. Thank you. Could I ask you briefly to look at the care and welfare of persons in police custody SOP, PS11014. If we can begin with section 1.1.2. There we are, this is "General", 1.1.2:

"It is essential that the care, welfare and security of persons held in police custody be maintained to consistently high standards."

And:

"... all custodies are to be treated with care and consideration, ensuring that their fundamental human rights are maintained. No custody should receive less favourable treatment on the grounds of age, disability, gender, race, religion or belief, relationship status, sexual orientation or transgender identity."

Can I ask you, does this SOP apply from the initial point of custody or apprehension?

A. Yes, yes, from the initial contact and the initial arrest, right through then all the transportation to the physical custody unit.

Q. If we had heard it suggested that this has nothing to do with a restraint which is taking outwith a police station, would you agree with that?

A. No, definitely not.

Q. Right, thank you. Could we look at page 12, please, section 5, and if we can begin with 5.1.1, the first part:

"Any person is considered to be in custody the moment they are apprehended."

And is that -- does that set out why this SOP applies?

A. Yes.

Q. And then can we look at 5.1.3:

"Any apprehension should be made with the minimum amount of force necessary. Any use of force required to affect an apprehension must be recorded in the custody record in accordance with the criteria for the use of force contained within the Use of Force SOP."

So does this suggest that there's a custody record if they're in a police station?

A. Yes.

Q. But again, links in with the use of force SOP that we looked at earlier today?

A. Yes.

Q. And then 5.1.4:

"A person apprehended must be promptly informed, in a manner he or she can understand, of the reason for the apprehension. If a person is incapable of understanding the reason for their apprehension or is so violent as to

pose a risk to themselves, Police Staff or any other person, this may be delayed until he or she has sufficiently recovered, or an appropriate adult, interpreter or translator is available to achieve this aim."

So again, is this recognising the importance of the person's understanding?

A. Yes.

Q. And then can we look at 5.1 -- sorry, 5.3.1. There we are. This relates to "Custodies suffering from injury/illness/intoxicated by drink/drugs":

"In certain circumstances a custody must be taken directly to a hospital after apprehension rather than being taken to a Custody Centre, to ensure suitable medical assistance is provided at the earliest opportunity and this may require the Arresting Officers to summon an ambulance crew or remove the custody directly to hospital."

A. Yes.

Q. And is that consistent with what you said earlier?

A. Yes.

Q. And then 5.3.2:

"Any requirement for immediate or urgent medical provision takes priority over apprehension. These circumstances may include where the custody ..."

And there are a number of bullet points there, let's have those on the screen:

"Has suffered a head injury;

"Is, or has been, unconscious;

"Has suffered serious injury;

"Is drunk and incapable; (unless local arrangements are in place... )

"Is believed to have swallowed or packed drugs;

"Is believed to have taken a drugs overdose;

"Is suffering from any other medical condition requiring urgent medical attention;

"Is suffering from any medical condition that the arresting officer believes requires treatment prior to detention in custody; or.

"Has been exposed to CS Spray/PAVA Spray and they experience difficulty in resuming normal breathing; or if any other adverse reactions are observed."

A. Yes.

Q. And again, is that consistent with what you said today?

A. Yes.

Q. Thank you. Can we now look on to the final -- back to the scenario that we're exploring and discussing today, but I'm thinking about the period from the moment that the subject is noticed to be unconscious or not responsive but breathing, and then a period of time

elapses until they are noticed to be not breathing.

A. Yes.

Q. So this is the distinction that was made where they're breathing but unconscious, until they're not breathing, so that period.

A. Yes.

Q. If that period is around four minutes, what would a reasonable officer be doing during that four-minute period?

A. Okay. So that would be the ambulance is called because of the unresponsiveness and then because it's an unresponsive casualty they must be constantly monitored and assessed, preparing for the -- in case CPR is required.

Q. And does that have to be monitored by the controller or the safety officer, or it could be any of the officers?

A. It could be any, it could be any of the officers, as long as they then agree that that person is competent to do so.

Q. And what does that constant monitoring look like on the ground?

A. So you're going to be constantly right beside the person's, like, head and looking down, listening to the breathing, looking for signs, you might then even be checking capillary refill of the fingers, but you're

going to be constantly --

Q. What does that mean?

A. It means where you press the nail and you see it goes from pink to white and then when you let go, the pink comes back, so normal capillary refill is near instant, but the slower the refill shows that the body's system is closing down.

Q. What's that due to?

A. It means the heart isn't functioning correctly, so it's showing that the cardiovascular system is failing in some way, so again, as a first aider, you're not a healthcare professional, it's just another indicator that is indicating that the capillary refill isn't right as well.

Q. And what's the purpose of this constant monitoring?

A. Well, twofold. One is that from the medical side, but the other thing is any person who is restrained is required to be constantly monitored anyway because of the fact that at any point they may go into a medical episode, but then the flip-side of that is in relation to any medical, what the European standard says is that any detainee must receive treatment comparable with if they weren't a detainee, so if as a police officer you came across a member of the public who has just collapsed and become unresponsive, they would instantly

get an ambulance called for them and what the European custody standards say is that same principle should apply to anyone within the UK who is held at the hands of the state.

Q. And are those European standards -- I think you said yesterday Scotland was seeking to observe those?

A. Yes, so all of the UK signed up to them to be mandated from 2006.

Q. Right. And if during the period we're describing the subject is handcuffed and has leg restraints and during that period there is an Airwaves transmission that officers -- it's open to officers to listen to -- that the subject has been struck to the head with a baton and may have been sprayed with CS and PAVA spray, what would a reasonable officer do in light of that?

A. Ambulance.

Q. Ambulance. And again, would it need to be an officer involved, or could it be an officer listening in?

A. It could be anybody. As soon as those risk factors are mentioned then you know that person has got to go to hospital.

Q. Could it even be an officer who is in a remote location --

A. Yes.

Q. -- like in a police office --

A. Yes.
Q. -- or an ACR?
A. Yes.
Q. And what would a reasonable officer do with the handcuffs?
A. Remove them, because if you have already established that the person is unresponsive when you're thinking then about the purpose of the restraints is to prevent the person escaping or assaulting, but if you have done your checks right and concluded they're unresponsive, then there's no necessity to keep the physical restraints on any more, because medical attention must be prioritised over the restraint process.
Q. And would that include the leg restraints being removed?
A. Yes.
Q. What would the reasonable officer do regarding perhaps the subject is lying on the ground, it's been raining that day, it's cooler weather, what would they do regarding a blanket or maybe covering the subject?
A. So the preservation of life and the immediate, like, first aid response would take priority over the other welfare aspects, but then if you've got sufficient staff then as well as staff dealing with the preservation of life and the first aid monitoring, then basic things like a jacket or a blanket over the lower part of the

body or the upper until the ambulance crews or anyone needed to get to the upper part, just basic things like that and if for nothing else, for public perception as well to show that the care and welfare is there in relation to the casualty, but you're trying to keep the casualty from losing body heat because the loss of body heat -- if the heart is not pumping correctly, the body is going to start cooling anyway, so then if the body is exposed to the elements, that's going to increase the cooling as well, so trying to keep the casualty with some warmth isn't going to harm them.

Q. What access do reasonable officers have to jackets or blankets or anything like that?

A. Well, I have seen officers take their own jackets off and put them over the lower part of the body, or gone to houses and asking do they have a blanket to put over people, I have seen officers do that on occasions.

Q. We have heard some evidence that an officer went to ask for a glass of water at one point.

A. Yes.

Q. They could presumably equally go to nearby people, residents...

A. Yes, "Do you have a blanket that we can use?"

Q. And after the person is noted in this position to be non-responsive but not breathing, again, is your

evidence the same as you have just described --
A. Yes.
Q. -- in what a reasonable officer would do?
A. You would commence the CPR and you would have all the restraints removed.
MS GRAHAME: Thank you.
I'm conscious of the time, would that --
LORD BRACADALE: Would that be a convenient point to stop for lunch?
MS GRAHAME: Yes.
LORD BRACADALE: 2 o'clock.
(1.01 pm)
(The luncheon adjournment)
(2.04 pm)
LORD BRACADALE: Ms Grahame.
MS GRAHAME: Thank you.
Ms Caffrey, I would like to move on to another issue and this relates to the time things take over which decisions are made by officers and actions are taken, so if we can look at a scenario where, following on from what we have been discussing yesterday and today, that the first officers arrive at the scene at 7.20.23 to be precise.
A. Yes.
Q. And those are the first officers at the scene in the

time and they're looking for a subject in light of the grade 1 calls about the knife incident.

A. Yes.

Q. By 7.21.19 -- now on my calculation that's about 56 seconds in total, but I'm very happy to be corrected on that, but the time is 7.21.19 that -- that is at the time an officer has pressed an emergency button and by that stage the man is on the ground.

A. Mm-hm.

Q. During that period of time, CS and PAVA have been discharged six times, the man has been struck to the head and body multiple times with a baton and has been shoulder-charged to the ground.

Now, bearing in mind your evidence about the actions of a reasonable officer, or reasonable officers, and bearing in mind the minimum force principle and the attempts by reasonable officers to observe preclusion, do you have any comments about the duration at which those events took place, the period of time over which those events took place?

A. My initial feelings when looking at how many uses of force were used in that period of time was that that was a lot of use of force within that period of time, especially when you start thinking about some of the timing with the CS and PAVAs because the average -- if

the CS is full there should be six seconds of use in a can of CS, and if the PAVA is full to empty, it's about 10 seconds of use in PAVA, so thinking about it, if they used -- that's time as well and then -- everything just seemed to be a lot in a small period of time. Now, that's not to say it wasn't necessary, but it's a lot in that time and all the time thinking about preclusion, the amount then of tactical communication, for that to occur as well. Tactical communication can be a lengthy process, or it can be a short process, but it's trying -- it's trying to use the lower levels before the use of force.

Q. And are there any limits on the time that officers, reasonable officers can take to communicate, build rapport with a person?

A. There's no time limit at all.

Q. So again, it depends on the circumstances?

A. Yes, and it can be beneficial to, in some ways, stretch out the communications, especially if you're aware of other resources attending and specialist resources. The more that you can delay having to approach the person and delay it through communication, then that can be beneficial.

Q. And is that what you were saying yesterday about buying time?

A. Buying time, yes.
Q. For other units, other resources, other specialist resources to attend the scene?
A. Yes, and it gives you thinking time. It's buying time for other resources to get there but it's buying you time to think and start thinking about what checklists -- you know, what options do I have?
Q. And to feed that back to ACR?
A. Yes, yes.
Q. And perhaps if you're buying time and able to buy time that that gives time for those resources to arrive and gives you more options if you're a reasonable officer?
A. Yes, yes.
Q. Thank you. Now, there may be some comment that although we're talking about hypothetical scenarios today that perhaps it's easy for us to sit in the calm of an inquiry hearing -- some of us may feel calmer than others -- but that fails to recognise the reality on the ground and, you know, events can escalate very quickly, they can deteriorate very, very quickly.
A. Yes.
Q. What -- have you had regard to that reality or possible reality in your evidence today?
A. Definitely. I mean another example I can think of is I was on patrol as the sergeant with a male constable.

He had lengthy service. He was taller than I was. We went to what we thought -- we were going to arrest a person in relation to breach of bail. We knew the particular male in question and usually he was of no high risk. We knew where he was living, so the male officer went to the front door for knocking on and I went round to the rear door just in case he tried to slip out the back, and based on previous knowledge, I was thinking about, you know, the NDM and thinking about the risk, I was quite happy as a young, fit woman at that point that there was no high risk to me if he came out at the back door.

So then I was next aware of a commotion within the property of just loud bang, bang, bang, bang coming closer and the next thing the back door opened and this male officer and the subject came hurtling out of the door and it looked like -- this young man that we had gone to arrest, he was smaller than I was, but the officer who was in excess of 6-foot -- it's -- the impression I got was that he had the officer off his feet. I know in reality he wasn't off his feet, but it was as though he had just picked him up with this, again, this like superhuman strength and that then -- I mean it was a shock to me because it was outside of what we had assumed would occur. Seeing how he was

handling the male officer, I instantly then got my baton out and racked it, and at that point this one was the PR24 baton which is the one with the side handle bit, not the asp, the asp replaced that one, so I racked the baton as the young man just seemed to throw the male officer across this back yard. Then he turned to me and he just stood there and made himself -- he just appeared as though he suddenly went 6-foot tall and just pumped up, and I had my hands out and I just said, "Keep away", or words to that effect, and he just started slowly, like in slow motion moving towards me and growling, in effect.

I knew the male officer was in a heap over in the corner area and I swung the baton as I said "Get back", and I swung across at his leg which was the primary target area. As the baton came back up and he is still just slowly walking towards me I said again about "Get back" and hit the thigh on his right leg, and at that point I looked at the baton because I thought "Has it racked?" I thought it had maybe failed to open and I was just swinging into air, but it hadn't, so at this point his arms were up like this (indicating) and I hit across at what would be his left arm and again, nothing happened and then he just seemed to do a -- I don't know whether it was a smirk or what, but just his face just

changed and by this point he is sort of this distance (indicating) but it was just a really slow but very intimidating move towards me, and at this point I was still thinking where next to hit and I just thought I don't want to hit the head because I was thinking "Red is dead", but the other area then that I struck, I struck into the chest, because although the English version was the red, amber, green colour, so the sternum was red, around the sternum was the amber, so I hit across the chest as hard as I could thinking now: I don't know what else and at that point he just seemed to drop to the floor and again, at that point, two other officers came running in because -- sorry, as this had gone on, I had called up for urgent assistance as the two of them came out, so the other two officers then arrived and my other colleague who had been thrown across the yard, he was then there and the four of us managed to quickly get him under control, but then one of the first things I asked for was an ambulance to the location because it instantly -- it was out of character anyway but it was specifically out of character for him.

We then ended up going to hospital with him with the ambulance and then once he was cleared from hospital we took him to custody and then the healthcare professional, the FME, came to custody to examine him as

well because of the use of force that was used against him and he was bruised across the chest and the arms and the legs from the baton strikes, so I knew the strikes had hit, but it turned out -- because then afterwards he apologised to me for his behaviour and said he couldn't remember anything and I had been custody sergeant for him at times as well, so we had that sort of professional relationship, but he couldn't remember the actual event at the house.

Q. How long did those -- that sequence of events take at the scene, not as you went to the hospital?

A. Very quick really, because even though I'm saying he walked towards me slowly, it was like time slows down in your mind as you're seeing things happen because you're still looking at these checklists and thinking, you know, "Is this really happening? What do I do now?" So I think my mind was working quicker than reality was. It was a very quick event.

Q. Could you give us an estimate of the duration?

A. You're maybe talking about 10 seconds from them flying out of the door to him hitting the floor, we're probably only talking about 10-20 seconds tops.

Q. And in that experience were you observing the principle of preclusion?

A. Yes, thinking that there was only -- he was -- the fact

that he had thrown this male officer like he did, I just knew straight away with my demographics if he could pick this officer up, he could pick me up no problem. If he was able to throw this officer, he could throw me no problem, so then thinking about the risks, then the fact he was just purposefully then just staring straight at me and coming for me, he could have easily gone by to the gate but he was just coming straight for me, so thinking about then going straight to defensive tactics, I was still saying "get back" but then I drew the baton ready in case he didn't.

Q. So you were demonstrating with your body language and communicating --

A. Yes.

Q. -- what you wanted and also you mentioned you were giving feedback, or you were on your radio, I should say?

A. That was as they first came out, I then called out for urgent back-up to the location. I don't remember the exact message. I do remember saying "urgent back-up" to the location.

Q. And you have also mentioned you were pressing your radio --

A. Yes, the radio.

Q. -- for the ambulance at the end?

A. Yes, when we then ended up on the floor one of the first things I did was call for "Ambulance required at the scene".
Q. And at that -- in those circumstances, were you bearing in mind minimum force? You have talked about the different areas you tried?
A. Yes, because I was thinking there I tried -- I mean I -- I thought I was only at the back door as an over -- I wasn't actually expecting anyone to come out the back door, but then I tried the -- you know, the hands up, the backing off, because I think if -- I slightly moved back, but there was clear access he could have gone out of the gate of the yard as well, but he didn't opt to go that way, so I wasn't blocking the exit there.
Q. And you went for the legs first, the arms next, but not the head?
A. Not the head, no. I've never struck anyone in the head. Only because I keep thinking back to basic training all the time about "Head is red, red is dead".
Q. Right. So is it fair to say that in considering these circumstances, the hypothetical scenarios I have put to you, you have borne in mind that reasonable officers could be in a situation where events occur very quickly?
A. Yes.
Q. And does that minimise or diminish any of the evidence

you have given today?
A. No.
Q. Thank you. Can I ask you about -- take you back to the National Decision-Making Model and the risk assessment. Would a reasonable officer consider that a person's race was a relevant factor in assessing that risk assessment?
A. No.
Q. Why is that?
A. Because race shouldn't bear an issue on it at all.
Q. Right. If there is intelligence, the police are notified of a threat level at the time and -- would that -- would the existence of that threat level or intelligence about, say, a terrorist threat be something that could be factored by a reasonable officer into their National Decision-Making Model?
A. No, because then you would just be putting a blanket -- a blanket on something rather than it being intelligence-led, as in this particular person, or this particular group of people, names are, so then you -- you can't just say because of the colour or the sex or the gender of the person that that would be a blanket application.
Q. If there's information at the time that there is a severe threat level for police officers, is that something that reasonable officers would consider when

they're processing their NDM risk assessment?
A. They may consider the fact, the raised level, but then it would be wrong to apply that just to one group of people without any specific intelligence about that.
Q. And what would a reasonable officer be looking for to perhaps provide more of a link between the intelligence or the threat level information they had with a particular incident they were attending?
A. So you're particularly meaning the terrorism side?
Q. Mm-hm.
A. Well, if there was an indication of terrorism because of the serious national threat of terrorism, any indication of a potential link to terrorism, that should be the command and control system all over that and they wouldn't then be directing officers, unarmed officers straight into that and one of the things all forces will have available are plans in relation to different levels of terrorism threat.
Q. So if there is a genuine terrorism threat in relation to a particular incident, would a reasonable officer be right in thinking that would be information shared by ACR?
A. Definitely, because then you would need instantly a strategic lead on this, and the likes of the counter terrorism security advisors, the -- the officers who are

involved in the terrorism strand would be all over this as principal partners.

Q. In the absence of any of that, would a reasonable officer be able to assume that it wasn't a terrorist incident?

A. Yes, because you would assume that the first filter of risk assessment and dynamic risk has been conducted by the ACR, and that they have now decided it's not terrorism which is why you're getting it. It shouldn't come out of ACR with any -- with any concept that it's still terrorism. So that's not to say it wouldn't be, but it shouldn't be coming out of the ACR if there's any indication that it's linked to terrorism.

Q. Thank you. From your experience in training officers I'm interested is there any training that you know of, or indeed that you have delivered, that would assist officers in minimising the risk of them factoring racial stereotypes into their risk assessment?

A. Well, if we look back over the history of policing and diversity training, I attended the Home Office diversity train the trainer course, which was six weeks, in I think it was 1996 I attended and it was six weeks down in Bedfordshire at a place called Turvey, it was one of the Home Office training sites.

That then permitted me to deliver any kind of

diversity training within any of the Home Office establishments. Now, at that point because I had already -- in order to do that I also needed prior to that the Home Office law course so that was a 13-week course and then that was six weeks on top of that, so you built these things up as different modules.

I then went back to Cumbria and I designed and delivered some of the roll-out of the initial -- they called it community and race relations training at that point. I delivered during the first year of the roll-out. Now, the initial plan was after that that all training courses would be incorporating all the relevant strands of diversity, so then years later when I was then designing and delivering the custody training, for example, I would then ensure that as often -- as much as possible it was as diverse as possible and we were looking at all issues which would include race, sex, sexuality and disabilities as much as possible throughout the whole thing.

Q. So was there specific training that you're aware of from your own experience that assists officers in avoiding or guarding against any racial bias?

A. No, not specifically. It would be very much down to each force to design their own -- looking at performance needs analysis and training needs analysis, it would be

down to each force to establish at what level they wanted their staff trained. There was no one national standard that said "Every police officer has to have this", so you would find differences between each force in relation to whether the focus, for example, was mostly internal in relation to race relations or equality and diversity, or whether it was external or a mix.

Q. And as I understand, we will hear more evidence about training in the future, but can I ask you one final thing: in relation to -- we have heard about annual reaccreditation or recertification of officers.

A. Yes.

Q. And I think at one point I had said officers in Scotland do one day; I think that was incorrect, it's now two days --

A. Yes.

Q. -- every year. We heard some suggestions that equality and diversity is taken into account when they're doing use of force training, or OST training. What's your views on that?

A. Well, it's supposed to be, but then it's down to -- it's down to each individual trainer then and what emphasis they give on it, because they have their training objectives to meet but it's mostly around: can the

delegate do this technique, that technique, rather than: have you included an example about this and about that? So yes, the training is more aimed at performance task rather than the process within it.

Q. Thank you. Could you allow me one moment, please.

A. Yes.

(Pause).

Q. Could I ask you about your awareness, if you have an awareness, of deaths of black men in custody, perhaps after restraint, and whether that's something that's covered in OST, officer safety training?

A. Yes. The main case that was significant for me was the death of Christopher Alder which -- it was released -- the inquiry into it was released in 2006 by the Independent Police Complaints Commission, in conjunction with the launch of the safer detention guidance, so that one became quite a national, well used case study throughout custody training, but it was custody training rather than officer safety training, but then in custody training you're also teaching the theory of officer safety training and how it fits.

The downside is the only people who go on the custody track are either the custody officers, or the civilian detention officers, not all your mainstream constables, but Mr Alder, he -- he had been the victim

of an assault with a scenario of the one punch outside a nightclub. Because of his behaviour then he was considered to be disorderly. He had been taken to hospital. Again, his behaviour was considered to be disorderly rather than the by-product of a head injury. He was then released from hospital. The officers then took him to custody on the grounds of a breach of the peace. By the time they got to the police custody -- he was handcuffed to the rear but unconscious but they believed he was faking it and lay him face down in the booking-in area at the custody unit and it was some sort of 12 minutes later before staff realised that he wasn't actually fully conscious. The noises they thought was breathing was actually signs of -- it was not breathing normal and believed to be heading into cardiac arrest and then unfortunately he died.

So that incident was used by a lot of custody training in relation to the emphasis of the use of force, the first aid, the head injuries, looking at the racial aspects as well because that was brought up in the investigation as well about the racial aspects, the first aid aspects. It sort of held a lot of the topics which then safer custody was covering.

Q. Again, we will probably hear more about this at a later hearing, but does this also tie back to what you said

earlier today about the distinction between breathing and not breathing and normal breathing --

A. And not normal.

Q. -- and not normal breathing?

A. Yes.

Q. And the current view, or the view in 2015 would have been whether the breathing was normal or not normal?

A. Or not normal, yes, because throughout that footage you can hear him -- you can hear him breathing on the custody CCTV recording, but it's not normal. It was described as being something between a snore and a groan, but it wasn't normal breathing.

Q. Right. And that was in the situation where the man had a head injury?

A. Yes, but officers hadn't appreciated that there was a head injury.

MS GRAHAME: Right.

Thank you very much, Ms Caffrey.

Thank you very much.

LORD BRACADALE: Thank you. I'm going to adjourn to consult with my Assessors at this point.

(2.30 pm)

(Short Break)

(2.38 pm)

LORD BRACADALE: Now, are there any Rule 9 applications?

Mr Jackson and the Dean.

Ms Caffrey, I wonder if you could withdraw to the witness room while I hear some submissions.

A. Yes.

(The witness withdrew)

Application by THE DEAN OF FACULTY

LORD BRACADALE: Yes, excuse me, Dean of Faculty.

DEAN OF FACULTY: My Lord, your Lordship will, I hope, have seen a fairly lengthy Rule 9 application was submitted timeously on behalf of those that I represent. That was responded to by the Solicitor to the Inquiry indicating that the number of questions that had been raised by ourselves and by others were such that Counsel to the Inquiry didn't feel it was going to be possible to put all of the matters to the witness herself, and so it has transpired.

My Lord, there are a number of issues in the Rule 9 application that have fallen away, but there remain various issues that I would like to explore with this witness, and in addition to that, given her commentary on Mr Graves' evidence today, I would like to explore the extent to which she agrees with certain other aspects of Mr Graves' evidence that we haven't heard about.

I'm not sure, my Lord, if your Lordship wants to

hear from me on all of the paragraphs. I can certainly outline the various paragraphs that remain extant, but that will take some time in itself, or your Lordship might just trust that I will exercise all due economy in asking the questions of this witness.

LORD BRACADALE: Well, I mean the Rule 9 is designed to apply to lines of questioning rather than a whole series of specific questions, and I would welcome a submission from you as to what lines of questioning you consider have not been covered.

DEAN OF FACULTY: So the first of those, my Lord, relates to the qualifications of the witness to offer the opinion evidence that she does in a number of different aspects, and that might be said to be the first 28 paragraphs in the Rule 9, although, as I say, an awful lot of those have fallen away.

LORD BRACADALE: Well, that's my point. I wonder to what extent that issue, now that she has given evidence, is one for submission as to what weight I can place on her evidence.

DEAN OF FACULTY: Well, we have considered that, my Lord. The view I took and that I continue to take is it would be quite unfair for me to attack the credentials of this witness in a submission without putting to her the basis upon which I challenge her expertise and, my Lord,

I don't want to be unfair and I'm sure the Chair doesn't want to be unfair either, so in my submission that wouldn't be appropriate.

The second aspect, my Lord, really relates to the question of waiting for the dog unit.

The third relates to ABD, or excited delirium and the extent to which --

LORD BRACADALE: Just before you go on to that --

DEAN OF FACULTY: I'm sorry.

LORD BRACADALE: -- in relation to waiting for the dog unit, her report was compiled on the basis of the evidence available to her at 31 October.

DEAN OF FACULTY: Yes.

LORD BRACADALE: And then there's subsequent evidence which clarifies the amount of time that would be available for the dog unit to come which she has now taken account of.

DEAN OF FACULTY: Well, the evidence available to the witness would have included the evidence of Mr Stewart which said it would have taken 25 minutes.

LORD BRACADALE: Yes, yes, precisely.

DEAN OF FACULTY: This witness thus far has proceeded on the basis of 10 to 15 minutes. So it would be appropriate to explore with her the extent to which it would be appropriate to wait for the dog unit. As I understand it, she is still saying it would be appropriate to wait

for the dog unit. Now, that is a view that requires to be explored further, in my submission.

LORD BRACADALE: Well, I can't precisely remember what she said, but my impression was that she had taken account of a longer time, but I could have a look at that.

DEAN OF FACULTY: Well, certainly -- we can get the precise aspects -- certainly my impression from the evidence given by her yesterday and today is that she still holds to the view it would have been appropriate to wait for a dog unit.

LORD BRACADALE: Oh, yes, that may be the case, but for a longer time.

DEAN OF FACULTY: Yes, and that is something that requires to be explored, in my submission.

The third relates to what the witness has said about ABD or excited delirium, and that in part relates to her own expertise, but also in part relates to the actual available evidence regarding what the officers saw or should have seen at the time.

Then we move, my Lord, to the question of containment and the extent to which -- because that is again -- I mean, that's closely allied to the dog unit point, the extent to which containment was feasible. It's obviously this witness's view that containment was feasible; that is not something that is shared -- a view

that is shared and again, requires to be explored.

Then leading from that we then have --

LORD BRACADALE: So what questions does containment -- what questions relate to containment, sorry?

DEAN OF FACULTY: So containment, that begins, my Lord, with -- it's basically paragraph 79 onwards, through to 89, and then moving on from that we have the assessment of, first of all, the approach to Mr Bayoh; secondly --

LORD BRACADALE: Sorry, can you just expand on that a little bit: the approach to Mr Bayoh?

DEAN OF FACULTY: Yes, so this is paragraph 83, through to 88, and then we have the deployment of CS spray or PAVA, that's 91 onwards. Again, a lot of this has fallen away, so, for example, 97, 98, 99 have all gone, but again, it is appropriate that we explore that aspect of the witness evidence.

Then we have the reaction to Mr Bayoh chasing and striking PC Short. That's 100 to 102.

Then a few questions on the restraint itself, primarily 119 and 120.

I don't intend to put any of the miscellaneous points at the end, so that's 132 onwards, but -- and I would intend to wrap things up under reference to what Mr Graves has said and to see to what extent she agrees or disagrees with Mr Graves. We have had a lot of

agreement with Mr Graves today but not necessarily with the points in which the Inquiry will be most interested.

LORD BRACADALE: Well, we -- I departed from the ordinary arrangements for Rule 9, as you say, because of the scale of the applications, written applications, and in further pursuit of that exercise, I suggest that when I rise, after hearing from Mr Jackson, you and Ms Grahame should sit down and go through this application and identify precisely what the areas are that you require to -- you require to apply to me to allow examination, so if you can return to your seat, Dean, I will hear from Mr Jackson now, please.

(Pause).

Yes, Mr Jackson.

Application by MR JACKSON

MR JACKSON: Like the Dean of Faculty we have lodged a very lengthy Rule 9 application, and like him, much of it has been dealt with, and I had anticipated that when he had finished, more of it would have been dealt with, leaving me with less, and of course that remains to be seen.

I can direct you to the paragraphs in my Rule 9 which I'm particularly interested in, which are broadly speaking from 52 -- 52 and then from 66 to 86. These tend to deal with the situations involving PC Tomlinson and PC Smith and are all to do with what I might say are

criticisms of those two officers in the report by the witness and in her evidence.

What I thought might be better, subject to you of course, was I would cover the -- rather than doing them individually, but I think it would receive the same result -- what I wanted to do -- want to do is to put to the witness what has been said by Officer Tomlinson in his evidence about the matters she is critical of to see if she would comment on that in the light of what his evidence actually was, and I would also want to do the same as far as Officer Smith is concerned. That seemed to me to be better than going through, as it were, the individual paragraphs but by simply and reasonably quickly, I hope, putting that evidence that's been given by the officers to this witness, that would in effect cover all the individual things that I have raised in the Rule 9.

Now, I don't know if that makes sense or not.

LORD BRACADALE: Just before I turn to that, you made reference to paragraph 52, that relates to the practicality of diagnosing -- oh no, I'm sorry, I'm looking at the Dean's. Yes, let me just get your Rule 9 application out. Yes, 52, and is it just 52 or is it after -- apart from the second tranche that you mentioned?

MR JACKSON: No, I just said 52 and then I went to 66.
LORD BRACADALE: Yes.
MR JACKSON: Could I just add this: like the Dean, it seemed to me to be fairness in some ways to the witness to be able to put this sort of material I was intending to put to her for her comments. You may, Chair, say to me "Well, a lot of these things could be done just in submissions", and I get that, I do understand that, and like the Dean, I have given some thought to that, but I was left with the view, which I think he had too, that there is fairness to a witness also involved. I know these are not normal proceedings, but in any proceedings it is fairness to a witness in evaluating their evidence to put the sort of things that we were suggesting, albeit they could be made in submissions without putting them to the witness I suppose, but fairness perhaps suggested that we should put these things to the witness.

I may say I have already discussed with Ms Grahame what I intend to do in general terms and what I'm saying to you is how I wanted to approach it in general terms, rather than the individual paragraphs. I have already indicated that to Ms Grahame at the luncheon adjournment.

LORD BRACADALE: Well, what I will do is I will consider

your application, Mr Jackson, while the Dean and Ms Grahame spend some time on his and hopefully come to a decision in due course.

MR JACKSON: I should add again, I think I have said this, of course to some degree I was anticipating that what the Dean did might affect what I would then be asking to do.

LORD BRACADALE: I can see that. Thank you, we will adjourn.

(2.54 pm)

(The Inquiry adjourned until Friday 2nd December 2022)

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