**The Sheku Bayoh Public Inquiry**

**Witness Statement**

**Inspector David Bradley**

**Taken by [redacted] at the Scottish Police College**
**on 11 September and 24 October 2023**

## Witness details and professional background

1. My name is David Bradley. My date of birth is in 1972. My contact details are known to the Inquiry.

2. I have 12 years of Police Service. My current rank is Inspector. I joined the Australian Regular Army in 1990 as a commissioned officer, and subsequently commissioned into the Royal Australian Corps of Military Police, where I served for approximately 14 and a half years prior to transferring to the British Army, to the Royal Military Police, where I subsequently served for another seven and a half years. I continue to serve as a commissioned officer

in the British Army Reserve as firstly a Royal Military Police officer and latterly on the Army General Staff I then joined Strathclyde Police, as it was at the time, in November 2011. I've served in Strathclyde Police and then subsequently Police Scotland since then.

3. In terms of experience of training in physical skills, I received my first physical skills qualification around 1997 whilst serving in the Australian Regular Army and the Royal Australian Corps of Military Police. I have approximately 25 to 26 years' experience in physical skills training, police-related training, use of force training and the like. I hold or have held the following relevant instructional & professional qualifications:

    - Police Scotland Operational Safety Training Instructor.
    - Force Science Institute Realistic De-escalation Instructor.
    - Public Order Bronze Commander
    - Rescue Trauma and Casualty Care Practitioner.
    - British Army Team Medic.
    - Preparing to Teach in the Life Long Learning Sector Level 3.
    - First Aid Trainer.
    - Emergency First Aid at Work Practitioner.
    - Automated External Defibrillator Trainer.
    - British Army Personal Safety and Public Order Instructor.
    - Australian Army Oleoresin Capsicum Spray Instructor.
    - Australian Army Extended Range Impact Munitions (40mm Baton Round) Instructor.
    - Australian Army Individual Close Quarter Battle Techniques (Pistol).
    - Australian Army Small Arms Coach (Pistol).
    - Australian Army Military Self Defence Instructor.
    - Australian Army Close Quarter Fighting Instructor.
    - ASP Tactical Baton Instructor.
    - Australian Army Military Unarmed Combat Instructor.

4. I have the following relevant practical training and policy experience:
    - I presently co-author and oversee a rewrite of the Police Scotland Operational Safety Training Manual.

- I lead a Peer Review team responsible for the requirements of an MOU between Police Scotland and the Scottish Prison Service regarding the assurance of their Control and Restraint Training delivery.

- I developed an Operational First Aid Upskill Continuing Professional Development training package for Police Scotland officers subsequently integrated into mainstream Police Scotland Training.

- I chaired a multi agency working group to develop draft patient management and transport policy for Police Scotland.

- I conducted shooting incident reviews on behalf of British Forces Afghanistan and reviewed national shooting incident policy.

- I developed and delivered specialist operations training for select Iraqi Police in order to form an effective rapid reaction capability in the province in which I was working.

- I undertook training package development & delivery of enhanced conflict management, physical intervention and revised operational skills to the in-house security team at Royal Brisbane Hospital, one of the largest hospitals in Australia.

- I was responsible for the co-development, delivery and assessment of lesson packages and the provision of strategic program guidance to the Peruvian National Police on behalf of the International Committee of the Red Cross, delivering high risk arrest training within an international humanitarian law context.

- I co-authored the Australian Defence Force Military Self Defence training syllabus.

- I authored the first Royal Australian Corps of Military Police Defensive Tactics Policy.

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- I co-authored and subsequently co-delivered the initial Australian Army Defence Assistance Techniques (Civil Disturbance) training package.

- I commanded the Military Police element of the Defence Force Aid to the Civil Power Training Team that conducted community support, security and defensive skills training to designated soldiers in support of the Sydney 2000 Olympic Games.

- I planned and conducted innovative scenario based rules of engagement and practical firearms training for all Dili based Australian non-combat Forces.

- I developed a concept of operations, recruited, trained and deployed Military Police Working Dogs teams on Operations. The first time since the Vietnam War this had happened within the Australian Army.

5. In terms of my training roles within police forces in Scotland, I was posted as an Inspector in Learning, Training and Development at the Scottish Police College (SPC) in August 2020 in order to conduct a review into blended learning opportunities within Police Scotland and develop test of change related products to assess virtual learning concepts, whilst at the same time, seek opportunities to reduce pandemic related training backlogs. At this time I also commenced development of the service strength and conditioning programme in conjunction with the Scottish Police College Physical Education Instructors.

6. I then moved to a role as a Temporary Chief Inspector as Head of Operational Training based at the SPC in November 2020. In this post I lead Inspectors responsible for Probationer Training, Operational Command Training, Operational Safety Training and 3 command based Operational Training centres in the North, East and West .As a result of this posting I was broadly familiar with issues around the Inquiry. I was in that post for approximately 22 months. On finishing my time in temporary rank, I moved post to the Head of Operational Safety Training.

7. I then took up the appointment of Head of Operational Safety Training in September 2022 but, realistically after periods of long leave I commenced the appointment in, January 2023. I subsequently did my Operational Safety Training Instructors' course in March 2023 to certify me to conduct training in Scotland. Since that time I have taught a number of Operational Safety Training Recertification courses and remain an active instructor as well as Departmental Head.

**Current OST training for Probationers**

8. I have been asked how many hours are spent on the Operational Safety Training (OST) within the probationer training programme. The amount of hours for the initial seven-day training programme for OST in Module 1, the initial probationer training, is 56 hours, split over seven days.

9. I have been asked how those 56 hours are split in terms of how much time is spent on theory and how much time is spent on practical techniques and scenarios. At the moment, the program contains 7 hours on use of force theory. Four hours is spent on a theory lecture, plus three hours of self-study. Eleven hours are allocated to empty hand techniques (this includes three hours of consolidation time). Six hours are allocated to the use of rigid handcuffs. Two hours are allocated to the use of the straight baton, plus an hour of consolidation time. Two hours are allocated to the use of PAVA. Two hours of the program are assigned to the searching of persons, and an hour on violent prisoner removal. Two hours are assigned to water safety training, the use of spit hoods and cordons. An hour is spent on the application of fast straps. Students subsequently undergo 16 hours of instructor led scenario-based training. In addition to this I instigated refresher training periods during Module 1 training that assigned 3 x additional 90 minute periods of OST to student training to reduce skill decay and increase confidence in the OST program prior to operational deployment at the end of Module 1.

**Review of the OST training manual**

10. I have been asked how often the content of the OST manual is reviewed. Review of the manual has just commenced, as at September 2023, and is likely to be ongoing over the next 12 months. The last major review of the OST Manual occurred in 2017-18. In the interim time period a number of minor modifications have taken place, to my knowledge this is the first major revision of the manual since its inception. It involves a chapter-by-chapter revision and re-evaluation, and that remains ongoing.

11. I have been asked whether there are specific processes in place for review of OST training materials and, if so, what those processes are. I'm conscious that I've only been in the department effectively since January, so my knowledge will be limited to what's occurred since the time I assumed the appointment. My understanding is that Quality Assurance within Learning, Training and Development directed reviews are undertaken every two years.

12. One of the challenges I identified within the department on taking up the appointment has been around our governance. In my previous role I oversaw the appointment of a Compliance Sergeant in late 2022 to support improved governance and assurance, the decision for which was informed by lessons out of the Inquiry as well, around being able to source and track back documentation in its provenance. Steps are ongoing to be able to continue to ensure that we have robust, thorough and consistent governance around this issue. This includes clear written recording of changes to training material and the rationale surrounding any changes.

13. I have been asked whether there are any processes for learning from other police forces. We sit as part of what is now the National Tactical Advisory

Group (NTAG) that is represented by all constabularies, and meets regularly. The Self Defence Arrest and Restraint group (SDAR) was the previous iteration of NTAG, which Police Scotland again contributed to. SDAR remains as a strategic group only. We have a mutual sharing arrangement with NTAG as well to look to contribute to the sharing of learning and best practice. Externally, but within Scotland we work with and share learning between ourselves and the Scottish Prison Service. Additionally, we work at our other departments, such as Criminal Justice Services Division, which encompasses Custody and our Partnerships Division as well, where we draw advice and learning from, and identify opportunities for learning as well.

14. I have been asked whether this included any learning from other bodies such as the College of Policing. Yes, that tends to be done through NTAG. The secretaries of NTAG sit at the College of Policing. So, for instance, the coordinating sergeant is on staff at the College of Policing, and so any learning we would expect to get through NTAG and share through NTAG. Additionally Police Scotland holds a College of Policing PPST license so we can benchmark against training material within their Personal Safety Manual.

15. I have been asked how learning from meetings such as NTAG is then cascaded to the OST training department. I sit as Police Scotland's representative on NTAG, or in my absence, my deputy, the Departmental Compliance Sergeant. If we identify an issue that needs to be reviewed, it will go through our own internal governance processes, with representation made through the Head of Operational Training, to the Head of Learning, Training and Development for review and consideration, and then if they deem it of sufficient importance that it requires review and consideration external to LTD, to the Use of Force Monitoring Group, the national monitoring group to ascertain their opinions as to its implementation.

16. I have been asked whether there is normally a lessons learning exercise following a significant event such as a death following or during police contact. I have not been involved in an incident of this nature less the current Inquiry. Certainly, depending on the lead department, it's my experience that that does occur for injuries after police contact. For instance, after a recent injury after police contact in Criminal Justice Services Division, we were asked to review the circumstances and to contribute to that lessons process and provide our technical support and expertise. I would expect that we would be involved in any lessons process that involves any issues around restraint or any areas of our expertise.

17. I have been asked whether there has been any lesson learned exercise arising from the death of Sheku Bayoh. Yes, there is. Whilst I am unsure when it commenced, I sit in lessons learned meetings regularly since I joined the department. We keep rolling logs of lessons identified and report back regularly on our progress in implementing lessons as they are identified and considered. From our point of view, it's good practice for us to monitor lessons that are coming out of the Inquiry and where relevant to make adjustments to training as we go forward. Training is an evolving matter and we wouldn't want to wait till the end of an inquiry when we could make ongoing improvements to programming ensuring that our training is up to date and effective as possible.

**Use of Force Monitoring Group**

18. I have been asked about my role in this group. I sit on the Use of Force Monitoring Group and have done so since I undertook this role, though I had also sat on the group (less frequently) in my previous role as Temporary Head of Operational Training. My role as the Head of Operational Safety Training is to report on the status of Operational Safety Re-certification to raise issues for discussion, contribute and consult on and provide advice on operational

safety matters that are brought before the group. It's further my role to bring solutions new proposals to the group as well contribute papers and highlight key decisions for governance and assurance purposes. My Departmental Deputy / Compliance Sergeant is the secretariat for that and maintains the action logs and the record of decisions.

19. I've been referred to Position Statement 11 (SBPI-00355) at paragraph 54(d). This outlines that the Use of Force Monitoring Group (UoFMG) was set up in May 2016 and states "*The stated purpose of the UoFMG is (i) to provide a means to monitor to what extent and how effectively use of force is employed within Police Scotland and (ii) to monitor the overall direction and management of operational safety within Police Scotland. The UoFMG is responsible for the interrogation and review of recorded use of force to identify national and regional trends and to direct appropriate action.*" I have been asked how the UoFMG monitors the extent and effectiveness of the use of force. Firstly, it might be worth understanding the UoFMG's terms of reference are changing at the moment and are being finalised. There are no major updates, but the Chair has shifted from the Head of Operational Support Division to Head of Learning, Training and Development. The Head of Operational Support Division now sits as the Deputy Chair. In terms of how the UoFMG monitors the extent and effectiveness of the use of force, there's a number of means. Firstly, by analytical means. Our Analysis and Performance Unit created what's called "Power BI" Dashboard which is an analysis and presentation software tool that allows us to interrogate and track trends around different aspects of use of force, officer injury, tactics and techniques used and their effectiveness. Data is presented at service level down to Divisions with Divisions able to access and interrogate that data themselves. The group can then scrutinise that data and provide any advice and direction that it feels necessary to either my department or other departments, to allow us to target areas or issues as they arise.

20. I have been asked if injuries to the subjects is also a matter that is scrutinised. They are not at this time however it is a relatively new and developing analysis product and as a result of this question I approached the developers and requested this action be undertaken and they have agreed to do so.

21. I have been asked if the interrogation and review of recorded use of force is done by the same means. Yes, use of force reporting is quarterly from our Analysis and Performance Unit and the quarterly reports are reviewed within the Use of Force Monitoring Group prior to being released for publication. The group can examine, and again, where required direct any issues as they arise and interrogate those further or direct their interrogation, should that be required.

22. I have been asked whether all use of force forms that are submitted that go into that system or is that just a percentage of the forms. I can say that all use of force forms are recorded on the one system and contribute to the Use of Force Power BI Dashboard and external reporting.

23. I have been asked whether the UoFMG discusses serious incidents such as a serious injury or death arising from police contact. I've not been party to a discussion in my time in the UoFMG of that nature, to my knowledge, so I can't speak to whether it would occur at all. But in my opinion, it wouldn't likely occur until after the relevant inquiries have reported, be they PIRC or Crown-related.

24. Where they're relevant to us, the Operational Safety Training department would see reports from the PIRC. The department involved in the inquiry, say, Criminal Justice Services Division, would look to seek our advice and support in executing any recommendations or discussing any

recommendations that come out of those reports. An example of this is the Criminal Justice Services Division serious injury after police contact I cited earlier. Reports such as this provide the Department with an opportunity to make sure our policy was effective and reflected what the PIRC recommendation required.

25. Paragraph 54(d) also outlines the Use of Force Monitoring Group's Terms of reference. One of these is to *"To study use of force reports and recommend remedial action where appropriate."* I have been asked about how that necessary level of detail is gleaned from the use of force reports to allow the group to recommend remedial action. Often what will occur is that, where issues are identified, Analysis and Performance Unit will be tasked to do a deep dive and to come back with a report that allows us to look further at identified issues. For instance, one example I can think of that's occurred in my time would be the examination of police assaults in and around vehicles, where it was identified that that may or may not be an issue. Analysis and Performance Unit were tasked to undertake further analysis and research and report back to the Use of Force Monitoring Group to allow the members to review any possible remedial action, guidance, support that Operational Safety Training required at that point in time. The Group has the option to direct further action as a result of research like this.

26. Another of the terms of reference is *"to monitor the effectiveness of Operational Safety Training and make recommendations to improve same".* I have been asked how we monitor OST effectiveness. I have previously mentioned the use of quantitative effectiveness data though the Use of Force Power BI Dashboard which includes technique effectiveness. There is also qualitative data collected. Every officer whom undertakes Operational Safety Training in Module 1 or subsequent yearly recertification is given the opportunity to provide level 1 evaluation on their levels of confidence, as well as specific training feedback in order to inform program development.. The

use of both qualitative and quantitative measures allows us to review any issues as they arise as well and potentially take remedial action where required. Additionally, Police Scotland's Analysis and Performance Unit recently completed work around OST effectiveness with regards to officer injuries on duty as a separate piece of analysis., Our Analysis and Performance Unit is available to be able to do any directed work like that as well.

27. I have been asked if the reporting in relation to use of force is simply a binary option of effective or not effective. Yes, based off the tactics that they've used. There is an area for short narrative on the form. It may or may not be completed to significant detail. We get a significant amount of these forms as well, and so the analysis is done as best as possible based off that form.

28. I have been asked whether there are other forums in which the OST programme is scrutinised. The Strategic Level Your Safety Matters group will receive a regular report from me on Operational Safety Training matters at a higher level. Although they're not a deciding authority, they're a coordinating and reporting authority, so they will have an interest and occasionally ask questions or direct matters around OST to my department as well. The service Strategic Health and Safety group does likewise.

29. I have been asked about the historic difficulties with use of force reporting in terms of ensuring officers to complete use of force forms for all incidents in which force has been used. I would refer to my Analysis and Performance Unit colleagues who track these matters more closely than we do. I can say that the information that we've received from the Analysis and Performance Unit would suggest steady improvement around use of force reporting over time from our divisions. It is something that is consistently monitored and reviewed at UoFMG, and commented on and referred to by our Analysis and Performance Unit colleagues at the UoFMG.

30. I have been referred to the Use of Force National Guidance (PS18622) on page 3. This states,

> *"Police Officers should record details of all use of force in their notebooks or police issue mobile device including the reasons why force was necessary. Additionally, all staff are required to complete the electronic Use of Force Form on System to Co-Ordinate Personnel and Establishment (SCoPE), prior to the end of their shift.*
>
> *Completed Use of Force forms are automatically forwarded to the National Operational Safety Training Unit where they are reviewed. Forms may be returned to the submitting individual for clarification."*

31. The Use of Force form is an online form that's completed on the SCoPE system. I've been asked to explain the review that's undertaken by the National OST Unit. This will be around the accuracy of completion of the form. All forms require to be completed correctly in accordance with the guidance issued. If it's not completed to that standard, it will be returned to the officer or their supervisor to revise the areas that are required to do that.

32. I have been referred to be page 3 which continues *"On every occasion where Irritant Spray is discharged operationally, or in the case of an accidental discharge, there is a legal requirement to record the incident and report it to the Police Investigations and Review Commissioner (PIRC) within 24 hours."* I have been asked if this is a separate form to the Use of Force form. Yes, this is a separate form - The CS/PAVA spray discharge form. The wider PAVA policy document is presently under revision. This revision is being managed by a separate Short Life Working Group of which we are a part.

33. I have been asked whether Police Scotland use external advisors to inform Police Scotland's training programme. Not so much external advisors, but we'll use external trainers for continuing professional development where we

feel that their specific area of expertise may help us develop our own learning and our own understanding of current trends, current techniques and the like, to support and inform our instructors and the Heads of Department as to what direction we might take the programme.

34. The Operational Safety Training Department used Dr Peter Jones, for instance, who's a national expert in bias and unconscious bias, to be able to provide our instructors with a deeper understanding of issues around bias and help inform the development of our own content around bias and how it impacts use of force. Our own instructors would then use that information to look to develop draft product to be inserted into Operational Safety Training programs. What using external experts like that allow us to do is keep abreast of developments nationally and internationally, particularly where we wouldn't necessarily hold that level of expertise internally. This allows us to be able to broaden and deepen our understanding of subject matter that we're able to then contextualise and perhaps integrate into our own training.

35. I have been asked about whether external advisors or trainers are used in relation to the Operational Safety Training specifically. Yes. Again, we don't use external advisors, but we've certainly used other instructors or trainers nationally to inform our CPD developments around specific areas of skills, again, that allow us to then explore our own techniques and see if they remain effective or whether there's better ways to integrate training and the like.

36. For example, we used a UK based trainer called Andy Roberts, who's a Brazilian jiu-jitsu expert. Mr Roberts has modified that content towards law enforcement, particularly around the aspects of edged weapons, and so we ran an edged weapon defence workshop as CPD for the National OSTI Cadre. Mr Roberts also delivers similar training for the British Army. Again, CPD training like that allows us to compare something that's happening more

widely nationally and internationally to our own training, and look to see where and how we could potentially integrate more effective training into our own syllabus.

37. I have been asked about the lead medical advisor, Dr Stevenson and how we work with him in terms of providing input into the programme. Anything that we're seeking to modify within the programme, such as new or revised techniques are always reviewed by Dr Stevenson to allow him to assess that technique with regards to its suitability for injury potential and the like. No technique is authorised for insertion into the programme unless it's cleared by Dr Stevenson as our Clinical Governance Advisor.

38. I have been asked about whether he views every version of the manual so that he can comment on the medical content. I can, within my time in the department, confirm this is the case and the current manual revision is a good example of this. As I've mentioned before, every chapter of the manual is currently undergoing review. There is a medical chapter in the manual. Once that's drafted, Dr Stevenson will be given that in its entirety and asked to comment on it. Indeed, he has already got the current version of that specific chapter to make initial comments on. We would seek his agreement to the contents of that chapter in particular noting that he has already reviewed any technique changes or modifications before they are approved for use by officers.

39. I have been advised that Dr Stevenson has given evidence to the Inquiry that the only complete version of the OST training manual that was version 1.2 of the manual dated 2017, albeit that a few days before he met with the Inquiry to provide a statement (on 8 September 2023) he had received an updated version. Whilst I can't comment as to what occurred before I assumed my appointment as Head of Department with surety, that's probably correct because, again, the whole manual's not been revised since 2017-18. So

whilst, a number of techniques have changed recently – and Dr Stevenson has seen those specific techniques and provided comment on those before we took them to Use of Force Monitoring Group, because his commentary is part of what we would report to Use of Force Monitoring Group – the only relevant part of the manual right now that he would need to review (in addition to the medical chapter I have already mentioned) are our Operational First Aid Notes. Dr Stevenson reviewed those notes for us earlier in the year as we made significant program changes.

40. I have been referred to Module 4 of the OST manual entitled "Medical Implications and Mental Health" (PS18539) at page 6:

> *"ABD is a rare form of severe mania, and sometimes considered part of the spectrum of manic-depressive psychosis and chronic schizophrenia."*

41. I've been advised that Dr Richard Stevenson's statement (SBPI-00390) at paragraphs 80 and 81 comments on this quote and states:

> *"This is very similar wording to a section that I have already commented one in the 2013 OST manual (PS10938). I'll repeat my comment here that essentially this isn't accurate. "Severe mania" is very out of date terminology. Further, manic depression (now known as bipolar disorder) is a chronic or episodic mental illness. Schizophrenia, similarly, is a long term mental health condition. There are many mental health problems out there which may cause an episode of ABD. However, it is far more likely that drug or alcohol use is going to trigger it.*
>
> *I should also add that the paragraph does not appear in the version of the manual Police Scotland had provided to me, which was Version 1.2, dated October 2017."*

42. It has been put to me that it appears that at some point between October 2017 and July 2022 this material has been added. I have been asked to comment on this. I can't speak to the provenance of this as I was not the Head of Department at the time. What I can say is that the Manual is a number of years old, hence it's timely to review it as I have directed. I cannot envision a circumstance where, as the Head of Department, I would not seek to not put revised content of this nature through Dr Stevenson, particularly when it comes to ABD, given he's written on it extensively.

43. I have been advised that this quote from page 6 of our Module 4 of the OST manual (PS18539) appears to be taken from page 5 of the College of Policing's Personal Safety Manual, Module 4 Medical Implications (PS00073) at page 5 as the wording is almost identical. I have been asked to comment on this. Police Scotland have a licence with the College of Policing to be able to access their "Personal Safety Manual,", our equivalent of the Operational Safety Training Manual. Whilst I cannot ascertain with any certainty as to how this replication occurred it doesn't surprise me to hear that potentially there's duplicate information that sits in the CoP manual that's been transcribed into the Police Scotland Operational Safety Training Manual. It's not necessarily the way it will happen in the future because it's important that we work to our own internal scrutiny and governance processes. However, the College of Policing remains one of these external reference points that we would always look to benchmark against, whilst having our own active discussions around these sort of issues, and I think that's appropriate.

44. However, it is another example of why a document of this nature needs to always go through the Clinical Governance Advisor to be able to make sure Police Scotland is teaching the most up to date information to officers. I think that's where we're quite fortunate to have a Clinical Governance Advisor with

the qualifications of Dr Stevenson, particularly in this field, to be able to support us.

**Training in relation to knife incidents**

45. I have been asked whether there is any training for probationers or in recertification training in relation to who is in charge when a response team are sent to a knife incident. I can't speak to the specific training given to probationary officers as to who is in charge at a knife incident. It's not an area covered in Operational Safety Training recertification which focuses on the operational techniques to mitigate edged weapon threat.

46. I have been asked what training is given about communications with the area control room, particularly in relation to feeding back to the control room during a grade one call such as a knife incident.

47. I can't speak to the specifics of the probationer training Airwave syllabus as it outside my area of expertise. What we revise in operational safety training is noted in the OST theory recertification module (PS18568). For instance, on Airwave, it specifically covers emergency activation, the automatic resource location system, locking talk groups, urgent callbacks and the wearing of earpieces. An urgent callback is activated by pressing a certain key on the radio. It allows the controller to understand that you want to break into the talk group to speak to them.

**CUTT Principle**

48. I have been asked to outline the training provided to officers when attending an incident involving a knife and particularly in relation to the transmit aspect of the CUTT principle. Training on edged weapons and the CUTT principle, is found in Module 18 of the OST Manual (PS18553). CUTT stands for the

following: create distance, use cover, transmit and then tactical options, which means consider tactical options. In considering creating distance when it comes to edged weapons, we would seek, where operationally feasible, for the officers to create as much distance as possible, increasing their reactionary gap and increasing the time they have to react to changing circumstances and in particular, the actions of the subject. Officers are taught to withdraw to a position outside of a range of what we would term to be a delivery system where that is practical. A delivery system might be an individual, as it would potentially be if it was another type of weapon. In this case in particular, we would need to consider the distance at which the individual is able to press the attack with the weapon that they have in their possession. I'll come to some qualifiers around that and what that means in practice. Secondly in 'Use Cover' we refer to officers being able to shield themselves behind objects. The examples the manual gives are items like street furniture, vehicles, tables, chairs, or doors when inside.

49. In considering "Transmit," officers are trained to shout "knife" into the radio, irrespective of the type of edged weapon (it's unrealistic to expect them to define a particular edged weapon), so that all on the network are aware and the ACR is aware. We would look for officers to request immediate assistance if it is operationally feasible in the circumstances but, frankly, if the shout of "knife" is given on the radio, we'd expect assistance to be being directed on to them by the ACR controller. It's not unusual in these cases for officers to press their emergency button, and that would be a common practice when it comes to edged weapon possession and officers being confronted by edged weapons. We would expect them to vocally communicate this to any other officers who are around by shouting "knife" so that they are aware as well.

50. As far as tactical options go, the mnemonic then lists consideration of tactical options. It does include options like contain and negotiate, tactical

communications and maintaining reactionary gaps. It does talk about other potential options around PPE such as irritant sprays, batons, empty hands and shields. The manual (PS18553) advises, at page 3, not considering physical intervention unless there's an immediate threat to life or an assessed immediate threat to life, precluding other tactical options where we can, and that physical intervention needs to be risk-assessed and only considered as a last resort.

51. I think there are some important qualifiers around this. Firstly, we need to understand and accept that edged weapon threat is lethal threat. It's a concept that perhaps over time in UK policing has had to evolve to that level of understanding, but it's an understanding that's clear in the international policing community. There are no safe tactics for unarmed officers to be able to safely apprehend an active edged weapon subject without risk of very serious injury or death. There's nothing that our department can teach an unarmed officer that will allow them to effectively & safely disarm or subdue a subject that is trying to attack them with a knife.

52. When I say an active edged weapon subject I mean someone who is trying to stab the officer, or someone in possession of or who can readily access an edged weapon and bring that to bear against officers attempting to take them into custody. It's an extremely challenging proposition because the subject, where any of the conditions above are met they pose a similar threat to the officer and puts them in an incredibly dangerous position. Decisions to take a subject of this nature into custody have to be weighed against the safety of the officer and the safety of the wider members of the public, and the subject.

53. Officers do this regularly in the UK context and in Scotland where other options aren't available because they consider that the wider risk to the public necessitates them to act. Adding to the complexity of situations like these when we talk about creating distance in an open environment, that can be

challenging because it requires you to be at such a distance from a subject who is potentially armed with an edged weapon that making contact with that subject starts to become impractical. If you're close enough to be able to effectively make contact with the subject, you're close enough for the subject to be able to close the distance effectively and potentially use that edged weapon on you.

54. You are unlikely to be able outrun the subject as they move towards you because you are in equipment and armour; and you are reacting to the subject's actions. It will take you time to identify the subject action as a threat, time to process a response and then time to enact that response. Again, even if you do manage this, even if you're able to turn and run, to what end? We're putting officers in a challenging position here with regards to articulating what our expected outcome is in this set of circumstances? What's reasonable to expect of unarmed officers when they're faced with that sort of threat?

55. When it comes to using cover, there's a similar issue. You are balancing the idea of, say, for instance, getting behind a vehicle, but the subject, if they're not in a position where they are fixed in a location, can simply move around the vehicle. The CUTT tactic is not designed as a proactive tactic to mitigate sending unarmed officers to edged weapon calls. The CUTT tactic is designed to mitigate risk in reaction to getting attacked by someone with an edged weapon, and I think that's the real challenge here. Perhaps sometimes it's been misinterpreted as a pre-emptive strategy for unarmed officers to deal with edged weapon subjects.

56. I have been asked whether CUTT then only has relevance in the event that a knife is suddenly pulled out on an officer and if so, what other training would officers use when responding to a call that a person is in possession of a knife. It is my opinion that the CUTT tactic is a reactive tactic to be employed in response to spontaneous edged weapon threat and should not be used as

part of a mitigating strategy in dispatching unarmed officers to edged weapon related calls. It is my opinion, to an extent, again, this is an evolving concept in Police Scotland and wider within the UK. I consider we are seeing more armed policing authorisations in response to calls where edged weapon threat is present. Initial Tactical Firearms Commanders get more involved in these calls, recognising that where they have a confirmed call for a subject with an edged weapon that armed officers are better placed to be able to manage that risk because of their wider tactical options and better training that they receive. So more regularly now – not always, but more regularly now – we are seeing armed deployments to calls of edged weapons because we have a better understanding, I consider, now of the risk than we did in previous years.

57. Again, I'd offer that's not a unique Police Scotland issue; that's a UK concept that is evolving around training. We still see incidents around the country where officers end up facing spontaneous edged weapon threat, but, to my mind, in this present time, we are much more cognisant as a service as to the risks around edged weapon threat to unarmed officers and the tactics and capabilities that armed officers are able to bring to successfully and safely manage those incidents, and we see in my opinion, more armed officer deployments around those issues currently.

58. I have been asked to clarify if that would apply purely in relation to someone being reported to be in possession of a knife. You would need to speak to the initial tactical firearms commanders around how they make their assessments on this as it's not my area of expertise. I can only comment on what my observations are in particular, in my area of expertise, what the limitations are around unarmed officers in this instance. It will always be my position as the Head of Operational Safety Training that we should not expect unarmed officers to need to engage at close range with edged weapon subject.

59. I have been referred to a document called Guiding Principles On Use of Force report (SBPI-00356), which is published by the Police Executive Research Forum (PERF). I have been referred to page 98, which details a scenario and the training of officers to respond to that situation, being demonstrated to American visitors: *"Officers responded to a man with obvious mental illness wandering the street with a baseball bat. As the subject advanced towards their police car, the officers backed the vehicle up to maintain a safe distance. Once they exited the vehicle, officers established tactical positioning and communications, maintaining a larger reaction gap and a slightly higher profile with their baton and chemical spray because of the possible threat posed by the baseball bat. Officers used communication techniques appropriate for an individual experiencing a mental health crisis (for example, the officers removed their hats to enhance eye contact), and eventually convinced the subject to drop the bat and surrender."*

60. I have been asked to comment on the training demonstrated in this scenario as compared with the current programme. Firstly, it's a scenario demonstrating to our US colleagues alternatives around how we might deal with use of force. It's an idealised scenario that is designed to have a positive outcome in order to highlight aspects of communications and de-escalation training. I have been made aware that the scenario was a replication of a live incident and have viewed a video of the demonstration.

61. However, there are some challenges around the validity of drawing lessons on de-escalation with regards to that type of scenario as well. Critically, whilst the real scenario that the incident was created from had a positive outcome, outcome alone should not be the single criteria from which we draw lessons of success or otherwise. A positive outcome utilising unsafe tactics remains unsafe and officers should not be placed in a position where we expect them to attempt de-escalation whilst remaining at significant risk.

62. I am aware of a very similar incident / scenario in Paisley in September 2021 as an example where two officers were injured, one seriously, by a subject with a baseball bat in a public place.

63. As to the scenario outlined, firstly, the assumption is made that the subject is static with the baseball bat and will remain so; that cannot be assumed. I can understand why officers at that stage are static, but in considering a reactionary gap, as I explained around edged weapons, the officers are now in a position that when and if that attack became dynamic, they will struggle to get out of the way of the subject who's seeking to hit them with the baseball bat. The baseball bat's a good example as well because while we perhaps don't consider it to be a significant threat to officers we need to be conscious that an officer getting struck over the head or over the body repeatedly with a baseball bat potentially causes significant injury or death to the officer. So, when we use the term reactionary gap, we may need to be significantly further away than we perhaps think.

64. I note the distance the officers are from the subject in the specific demonstration. The officers likely appear to lay persons be at a reasonable distance from the subject. I would submit that the officers are at risk, with the subject able to rapidly close the distance to them should he have decided to do so. One of the key things we need to consider when we talk about de-escalation to give it a chance to be effective is the tactics have to be safe. We have to set up a situation where both the officer, the subject and the members of the public are safe to be able to engage in communications.

65. If it's not safe for officer, subject and public, then it's a real challenge, in my opinion, to be able to effectively engage in de-escalation or effective tactical communications. There's a couple of reasons for that. Firstly, if it is not safe for the officer, the subject or the members of the public, it is unlikely the officer (or subject) will be able to engage in complex thinking. To be able to engage

and listen and employ de-escalatory skills, officers have to be able to use complex thinking and access that part of their brain necessary to do so.

66. Where they're at risk, or where they feel at risk or where the threat is not contained safely, officers are more likely to revert to primal or reactive thinking. We see this phenomena with officers who often repeat commands. You see use of force instances where officers might be saying, "Drop the knife, drop the knife, drop the knife," or, "Drop the bat, drop the bat, drop the bat." That suggests the officers not able to engage in complex thinking at that point in time and are engaged in primal or reactive thinking. They're reacting to what they're seeing. So to start with, in order to engage in complex communications skills you have to be safe operationally.

67. You then actually have to be able to connect with the subject. I had highlighted earlier in my statement what that means in terms of reactionary gap and the challenges that poses in making an effective connection and speaking to the subject. If you're at an exceptional distance perhaps required by your reactionary gap because you're in open ground or the like, this remains challenging.

68. Add to this, you then actually have to be able to communicate with the subject, and the subject has to be clear of mind enough to be able to engage with the officer and indeed want to engage with the officer. When the subject's thinking is perhaps clouded or contaminated through mental illness or alcohol or drugs, then that can be difficult as well for the officer. But if the subject can't communicate with the officer, then it's unlikely that you're going to be able to engage in effective tactical communication or de-escalation. So there are a number of factors at play that need to be in place for us to be able to successfully employ de-escalation tactics. When considered alongside circumstances where discretionary time might not be available to the officer to attempt de-escalation due to the perception of threat to the public or other

officers and that a decision to act may be within the bounds of reasonable officer action, it can be seen that there is rarely a simple decision point between 'using force' and 'de-escalating'.

69. I would suggest that the scenario outlined within the PERF document is making the assumption that all of those factors are in place. Unfortunately, operationally, that can sometimes not be the case. We are presently working with our negotiators on the next iteration of our tactical communications and conflict management training to officers, and this is coming up as a factor: "How do we make sure that we are realistic in our expectations of what officers can and can't do under these operational stresses and challenges in effectively being able to establish tactical communications and employ de-escalatory language, and when should we and when should we not expect that to be successful?"

70. I have mentioned the effect if the subject cannot communicate with officers. I have been asked how officers can know if a subject is unable to communicate if it is not attempted. I consider it reasonable to suggest that in a high stress incident that can be challenging for officers. There are going to be times when there is not discretionary time for an officer, and that it is reasonable for them to act based off their perceptions of the risk and threat; noting it is their perceptions of the risk and threat that are important here as opposed to potentially objective perceptions. But if that puts you in a position where you are compressing time and space on the officer or the subject, then, again, that makes it difficult certainly for the officer and perhaps even the subject to engage in the complex thinking that's required to be able to do that.

71. You need to be able to make that connection first and you've got to be in a safe tactical position to do so. If you can't get yourself in a safe tactical position, then it starts to become a really difficult ask to expect the officers to be able to engage in what is a complex communication exchange.

72. In Guiding Principles On Use of Force report (SBPI-00356), at page 90, it notes that Assistant Chief Constable Bernard Higgins from Police Scotland, together with a senior police Officer from Greater Manchester Police, spoke to a PERF Conference on 7 May 2015. It states that they *"made it clear that in their agencies, general patrol officers typically equipped only with a baton, chemical spray and handcuffs would be expected to deal with the threat of a knife-wielding subject primarily through de-escalation and tactical approaches and without calling in specially trained public order officers or firearms officers unless the threat escalated."*

73. I have been asked, now 8 years on, whether that is accurate of the training provided to police officers in 2023. I don't consider this to be an accurate representation of Police Scotland training or expectations in 2023. It's not reasonable to expect officers to be able to deal with edged weapon threat just through de-escalation. The reason why that occurs right now at this time, is because when they are threatened with edged weapons spontaneously, the only the options they have are de-escalation, baton, spray and handcuffs. But it is not our expectation that unarmed officers deal with edged weapons threat and where it can be mitigated against by the deployment of specialist officers it should be.

74. Our understanding of edged weapon threat has evolved since that time, not just in Scotland but in the wider UK, to better align with international benchmarks on the nature of edged weapons threat. To further clarify why within Operational Safety Training we do not consider it reasonable to expect edged weapon threat to be dealt with by unarmed officers we need to consider what we are expecting the officer to be able to achieve, for instance, when de-escalation doesn't work? What are we expecting the officers to do if the set of circumstances changes and they are now faced with the subject trying to stab them with the edged weapon? Within Operational Safety

Training we can't give them anything safe to be able to deal with that specific incidence and only given them tactics of last resort to minimise the risk of injury.

75. So, in my opinion, it is unrealistic to expect an unarmed officer to manage anything other than the spontaneous edged weapon threat that we perhaps can't mitigate against and in so far only as it relates to reducing their injury potential. If the edged weapon threat is known and confirmed, then it's my opinion that we are in the realms of having specialist resources deal with that threat.

76. I have been asked whether the use of Taser and Specially Trained Officers (STOs) would have a role in a response to a knife incident. we need to be cautious as to understanding what Taser is for. Firstly, I am not a TASER Instructor and can only offer an opinion in as much as it relates to the implications of TASER on the application of Operational Safety Training techniques as they relate to edged weapons.

77. I don't consider TASER suitable in isolation for the management of edged weapon threat in and of itself. It can certainly be used (as it is internationally) in conjunction with other tactical options as used by our firearms officers to help bring an incident to a conclusion. Officers have used it to manage and attempt to deal with spontaneous edged weapon threat, but where we need to be cautious is again the expectation of unarmed officers, should TASER fail to have an effect on the subject. What is the expectation regarding safe tactics that our unarmed officers are going to revert to once that occurs?

78. Customarily, we are seeing TASER deployed initially to edged weapon calls, but again, I can't speak to the process of the Initial Tactical Firearms Commanders in making their assessment; that's a matter for them. What I can only say from my area of expertise is that deploying Taser alone to a

confirmed edged weapon call entails a degree of risk in that if the Taser does not deploy effectively, then the officers have no means to control that set of circumstances and find themselves in the same position they were without the Taser that I have outlined earlier.

79. So whilst it has become customary not just in Scotland but around the UK to deploy TASER in isolation to edged weapon call, I do think we need to be cautious in perhaps identifying TASER as any form of panacea for unarmed officers to manage edged weapon threat. It's certainly an option if they are equipped with it and they are faced with spontaneous edged weapon threat, but again only because they don't have other realistic options. Taser is best employed in managing lethal edged weapon threat covered by other specialist officers and tactical options.

**Threat Assessment**

80. Guiding Principles On Use of Force report (SBPI-00356), at page 100, it states *"Consider the nature of a threat, not just the weapon itself: Police Scotland officers are trained to look not solely at the weapon a subject may possess, but also at the threat it poses. Is the knife being swung about, and if so, is it being done offensively or defensively? (A person with a mental illness may see others as aggressors, and so he might swing his knife in a defensive manner to keep people away.) The threat posed by the weapon, and not just the presence of the weapon itself, helps determine the specific tactics that are employed."* I have been asked if this reflects current training within the OST programme? Yes I consider the concepts presented above are accurately reflected in current training. All officers are briefed on the concept of Jeopardy in undertaking a threat assessment, which incorporates understanding subject threat through the lens of means, ability, opportunity and intent.

81. Officers are also taught through their understanding of National Decision Model principles that they should continue to reassess information to inform their understanding of risk. So, a static possession of an edged weapon, for instance, can change rapidly, potentially to a dynamic presentation of the edged weapon. Realistically, the officers, under significant pressure, particularly if they're unarmed at a scene such as that, are going to be challenged in a manner that is not regular for them and their ability to be able to cognitively process these changes is likely reactive and instinctive in nature based off their level of training and previous experience, rather than deliberate and considered. We should temper our expectations on their performance based off an understanding of those limitations.

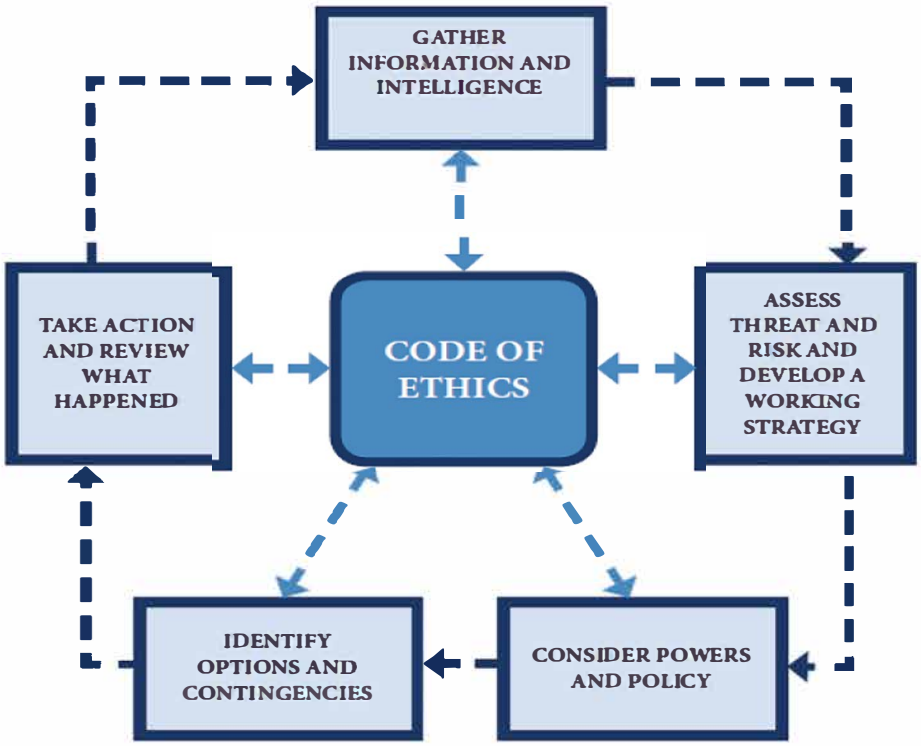
82. I have been asked to clarify whether, in terms of considering the threat of a person in possession of a knife, that training includes consideration of the risk that a person may be actively attempting to harm them. Yes, that is incorporated into our current training. Hence, employment of the CUTT principles is important, as are the mitigating physical tactics that we teach, as is seeking to negate the requirement for unarmed officers to be placed in a situation where they are exposed to edged weapon threat. We understand and expect that there are times, based off our current deployment model, that that can occur and we want to make officers acutely aware of the risk posed to them by edged weapon threat and we do.

**Training on dynamic risk assessment**

83. I have been asked to outline the training that's given in relation to carrying out a dynamic risk assessment. Officers in their initial training get education on the use of the national decision model (NDM). As part of that model they are taught principles of performing a dynamic risk assessment. They also get those in their recertification training as well. They're both covered in theory and debriefed in scenario-based training as well.

84. I have been referred to Module 2 of the OST manual "Conflict Management" (PS18537). Again, it's worth being aware that this manual is currently under its probably most significant revision since 2017 incorporating all of the lessons that we've identified from the Inquiry as they occur but also our greater understanding around things like the use of the NDM.

85. The easiest way to explain the NDM is to use the diagram below, which appears at page 3 of Module 2 of the OST manual (PS18537).




86. Page 3 of the manual explains the use of the NDM as follows: *"The NDM has six key elements. Each component provides the user with an area for focus and consideration. The Code of Ethics is connected to and supports the five stages of the decision making process. One step logically follows another, but the model allows for continual re-assessment of a situation and the return to former steps when necessary. This allows the officer/staff to use the model*

*with a degree of flexibility, assisting with their dynamic risk assessment and decision making. An officer/staff may apply the NDM in any given situation both consciously and subconsciously. This may be before, during or after an incident."*

87. The first stage is gathering intelligence. They will get that information from potentially a number of sources, but initially, likely the call that they're getting off the radio through information passed by witnesses or systems checks undertaken by control room staff or on their own mobile devices should time allow. They'll look at if there's any victim involved or they'll look at the location, if they know anything about the location. They might be making some preliminary assessments of what that location entails and what the impact of that is, and they'll be thinking about what information is being provided on the subject.

88. When we're talking about subject this means identifying the subject, their capability and their intent. They're asking themselves a number of questions about what's happened, what I know, what information do I want, what are they asking at the control room, for instance, how are they looking to get it.

89. Stage two is "Assess threat and risk, and develop a working strategy". they're taking into consideration what they've learned already around the subject's intent, the "victim, subject, location" capability, and they're forming a risk assessment around, "Is this an unknown risk incident or is this a high-risk incident?" We only have two forms of risk. We don't expect or teach officers to assess an incident, for instance, as "medium risk" or "low risk." There's too much nuance there, and it's operationally challenging to do so. Where officers assess a subject as unknown risk we expect them to still employ safe tactics when they're engaging in any interaction at that point in time.

90. In considering the development of a working strategy, the more time and space in a safe environment that officers, and indeed supervisors, are able to have at their disposal, the more developed a strategy like that will be, and it will often be formalised on an incident as the agreed working strategy. It's not unusual to see some of the things that you see in the appropriate chapter in the manual around maximising the safety of the public and the subject, and minimising the risk to police and other emergency responders, preserving the scene, gathering evidence and the like. More dynamically, it's likely a lot less than that. It's likely quite reactive. It is likely around identifying the subject, keeping the subject safe and keeping themselves safe, and keeping the public safe. It can be that simple, but that does not mean it's not an effective working strategy, but it's rarely as detailed and laid out as you see for a dynamic incident as a protracted incident or an incident whereby officers and supervisors have more discretionary time for consideration.

91. On page 5 of the Module 2, it states *"Threat assessment means accurately assessing any person, object and place".* I have been asked to explain more about this. "Person, object, place" is a common methodology of threat assessment, and it is exactly as it reads. You're looking at the subject's actions, their demeanour, their ability. You're looking at any objects or weapons they've been reported to have or do have in their possession, and you're talking about the environment you're in – "Are we in a flat? Are we in an open environment? Are we in a stairwell? Are we in a school?" – and looking to make your threat assessment around high risk or unknown risk based off that information that you have at the time.

92. At pages 6 and 7, Module 2 outlines warning signs, danger signs and impact factors. Warning signs and danger signs are essentially looking at the body language and the actions of a person and taking that information as part of your threat assessment. Warning signs and danger signs highlight some

common presentations that might support an officer's information/intelligence gathering and risk assessment.

93. What I would say to that is there are eight warning signs and ten danger signs listed. Officers are not going to remember those 18 signs. They will instinctively react to what they see and on reflection they might be able to effectively categorise and identify those that may have been present, We do need to caution ourselves when we say, "Officers are trained in warning signs and danger signs." Yes, that occurs and that occurs yearly and is subsequently able to be applied within the limits of their memory, ability and the level of threat, and subsequently cognitive load they're facing at the time.

94. Impact factors are the human and environmental differences that make each incident different and unique. They can have an important influence on how the officer reacts and the tactical decisions that they revert to. We encourage officers to articulate them on reflection. Impact factors allow us to identify why each incident is unique, and it explains why two officers, faced with exactly the same set of circumstances in front of them, may react differently because their perceptions of impact factor and subsequently , their perception of their ability to deal with the circumstance in front of them with the tools that they're able to recall and feel confident in executing might be different.

95. As a simple example: A significant size difference between an officer and the subject, for instance, the subject is significantly larger than an officer, may result in the selection of a different tactical option than an officer of the same size or perhaps bigger than the subject, based off the officer and subject's perceived ability and the perceived risk.

96. Profiled Offender behaviour is split into six categories, which are as follows, and this is on page 8: compliance, verbal resistance and gestures, passive resistance, active resistance, assaultive resistance, and serious and aggravated resistance. I have been asked about the reasonable officer's

response to each of these categories. This is a good example of where impact factors will influence what we would consider to be an officer's reasonable response. An officer's reasonable response to any of these might be very different based off their impact factors, their perception of the threat versus another officer, and so, within reason, we would be guarded in saying, "If a subject does this, then you do Y" because it's more complex than that. I'll discuss this further in the context of the tactical options model.

97. Page 11 of module 2, outlines the guidelines for conducting a dynamic risk assessment. These are:

> *"• Duty to protect/preserve human life; which includes their own.*
> *• Should be aware of their physical limits –never take unnecessary risks.*
> *• Should advise someone what they are doing (or going to do) and try to get support before they do it.*
> *• Should seek information and advice – this will aid officers/staff to make a judgement.*
> *• To apply correct procedures in every situation.*
> *• Will record their decision making process either at the scene or soon afterwards in an official notebook or other recognised journal.*
> *• Supervisors and managers are there to assist* and offer guidance."

98. Stage 3 is considering powers and policies. This means considering what is a lawful basis for action. The officers are considering, "What is a lawful basis for action in this case? Is it lawful for me to use force or otherwise? What Police Scotland policy covers these circumstances, and what does it say around this issue? ECHR compliance influences these decisions, but again, I would caution against suggesting that officers in a high-risk, dynamic, fast-moving situation are considering these detailed points of policy and law, and going through, for example, ECHR articles. They'll be aware of their broad

obligations with regards to powers and policies, and they'll be aware of absolutes, but they'll be reacting to perceived threat.

99. Stage four is "Identifying options and contingencies", and this includes tactical options. This is where we start to consider concepts such as preclusion. In a dynamic set of circumstances, this will happen rapidly. Perhaps not cognitively, they will be reacting to threat and they'll be selecting a use of force option that comes to them, based off their experience, ability and the cognitive and physiological load placed on them at the time, and their perception of the threat. That will be individualised, based off those factors for each officer and the set of circumstances facing them and the impact factors that we've already explained. So, the longer the timeframe, the safer the incident, the more an officer has an ability to be able to engage cognitively, then the more likely that that is a more deliberate and more formalised process.

100. I have been asked what officers are taught about principles of preclusion, justification, and necessity in relation to use of force.In use of force theory training officers are introduced to Police Scotland's Test of Reasonableness as outlined through the mnemonic PLANE: Proportionality, Legality, Accountability, Necessity, and Ethical actions.

101. With regards to proportionality officers are taught that for use of force to be justified it must be proportionate to the level of resistance or threat faced. They are also taught that force might not be justified if a less injurious but equally effective alternative existed and that the amount of force must be the minimum required to achieve the lawful objective.

102. With regards to Legality officers are taught that there must be a legal basis for taking action.

103. As to accountability officers are informed they must be able to account for why they chose a particular course of action. This includes what courses of action that might have been open to them that they did not select. This is known as the concept of preclusion and includes options that may have been tried and failed or not considered appropriate given the circumstances.

104. With regards to necessity officers are taught the use of force must be absolutely necessary in the circumstances and critical to the safety of officers and staff in the course of their duty.

105. As to Ethical Actions officers are taught that they will be expected to act in accordance with the principles of conduct aligned to Police Scotland.

**Use of the NDM in situations involving spontaneous or significant threat**

106. Spontaneous incidents or incidents involving significant threat, such as knife incidents, are dynamic by nature. I think we have to be cautious about suggesting that an officer will always use a national decision model when they arrive at an incident scene, particularly if there are only seconds for them to be making decisions around courses of action. As we move forward and adjust our training and look to teach officers this, we have to be in a position, where we take more cognisance of that so that the reasonable officer is held to account for what are indeed reasonable actions given their level of training, the operational stresses that they're facing, and the decisions that they are required to make in very short time. That is a genuine challenge, but it's one that I feel that we have to tackle for the safety of subjects, public, officers, and to allow officers to be held to account honestly given the investment we wish to make in training in them.

107. We need to acknowledge that the use of the NDM is a complex thought process. Again, it's perhaps not reasonable to expect when officers are faced

with spontaneous threat or a significant threat that weighs on them cognitively and physiologically that they will be able to use and employ the national decision model in that very short and heightened time frame.

108. That's not to say that officers won't engage in a process of risk assessment. Just that it's more realistic to expect that when faced with spontaneous risk or heightened risk that the risk assessment process will be more reactive and schema based in nature. Officers will revert and react to their training and employ what they can pull from that in that challenged cognitive and physiological state in response to their immediate perception of the threat. In that framework, the NDM becomes a more effective reflective tool to be able to articulate their thoughts and their actions in that very abbreviated time frame. Improving officer's decisions in these circumstances relies on regular, effective and realistic training.

109. It's not realistic, in my opinion, to expect that officers are cognitively and consciously using the national decision model in that perhaps extremely short, extremely heightened, high-risk time frame where they're unlikely to be able to access and engage in complex thinking because of what's happening around them and the cognitive attention required for them to be processing and managing the threat whilst they are in a state of reactive thinking.

110. So, again, where circumstances are more static where officers are safe, where the subject and members of the public are safe and we're not seeing anything pressing or causing reactions, officers are then able to access more complex thinking and therefore are more likely to be able to employ NDM-based principles in managing a situation. Again, some of those same principles apply as being able to look at effective tactical communications and conflict management or de-escalation in that we have to be in a position where we're able to have the time and space to safely enable that model during an incident.

111. Post incident, the NDM becomes an effective reflective model to be able to reflect on actions and discuss why certain actions were taken, because officers will observe things and react to things that perhaps in the moment they're not consciously reacting to, but on reflection they'll be able to draw on and to look at how it impacted their decision process.

**Tactical Options Model**

112. Page 13 of Module 2 of the OST manual (PS18537) states:

*"At the heart of the tactical options model is Police Scotland's criteria for use of force. Officers/staff must ensure that any force they use must be:*

- *Proportionate, Legal, Accountable, necessary and ethical.*
- *The action taken must reflect the values of Police Scotland (Integrity, Fairness and Respect).*
- *Did the action meet the standards expected of Police Scotland?*

*Officers/staff must thereafter take cognisance of* ***Warning/Danger signs, Profiled Offender Behaviour*** *and* ***Impact Factors*** *to assess the risk, and choose the most appropriate tactical option."*

113. I have been asked to comment on this. With regards to it being proportionate, legal, accountable, necessary and ethical, we know that is our test of reasonableness. I have outlined this test earlier in my statement. Officers are cognisant of that. They are revised in that yearly, and howall aspects of the tactical options model come together to help them make that decision or help them formulate a response and a reaction that sits within those boundaries. Officers are held to account and assessed against that

when it comes to Police Scotland's test for reasonableness regarding the use of force.

114. Page 14 of Module 2 provides a diagram of the tactical options model:


115. The model works from the centre moving outwards. What the model demonstrates is that the officer's perception of warning signs and danger signs contribute to profiling the subject behaviour, overlaid against the impact factors that are potentially present at the scene. They assess risk at that point in time and make their risk assessment. Based off their risk assessment, there are tactical options for them to explore based off their personal protective equipment options, and you can see a number of them around the model. Certainly, it's of use reflectively to be able to identify why an officer did

certain things. Again, when we're talking about a dynamic, high-risk, fast-moving incident, it's likely less cognitive and more reactive. The officers are going through these concepts and identifying their response rapidly based off what they're perceiving is the threat in front of them.

116. I have been asked to explain how officers are trained to assess that a tactical option that involves a use of force is necessary and proportionate in a situation. Officers are briefed as to the components of the test of reasonableness and what they entail. This combined with their understanding of the tactical options model allows them to select appropriate options based off the unique circumstances of the incident. As I have outlined for fast moving and dynamic incidents this can be reactive based off the perceived threat of the subject and their assessment of impact factors/their ability, and their assessment of what needs to be done to control the circumstances. In a more deliberate, slow moving incident, their assessment will be more considered.

**Training regarding Intoxication/Mental health crisis/ABD**

117. I have been asked what training is giving in relation to identification of subjects who are intoxicated due to drink and drugs, or individuals who experience a mental health crisis, or experience an ABD or excited delirium. Excited delirium is not a term that we use anymore, but we refer to it just because it's a more commonly known term, but we use the term acute behavioural disturbance (ABD). These subjects are covered with officers in the new operational first aid manual (PS18581). We train officers to recognise and manage a casualty who is suffering from alcohol/drug intoxication, recognise and manage a casualty who is suffering ABD and explain the risk factors associated with positional asphyxia. However, I would defer to my colleague, Phil Briggs, the lead for Operational First Aid in relation to the content of that and any further detail.

118. I have been asked how long is spent on theory training in relation to positional asphyxia and ABD. In the initial theory training 20 minutes is allocated to positional asphyxia and 25 minutes to acute behavioural disturbance. However, I would also explain that when we're conducting the physical aspects of the training, where positional asphyxia, ABD or other medical considerations are relevant, it's highlighted again at that stage for officers. For instance, when they're doing violent person teams around custody or they're doing ground holds and ground pins, officers are reminded at that point in their training of the risks of positional asphyxia for those relevant parts of the physical syllabus, so it's not just covered in theory. That theory is applied in the practical environment and their reaction to medical incidents after the use of force is integrated into scenario-based training as well.

119. ABD is also integrated into practical training. However, it's less common currently. It will become more common as we move through revisions of the programme, but yes, opportunities are taken, where it's appropriate, to be able to identify ABD as a risk around circumstances like irritant spray, but it's something that I would see us doing more of in the future because of the challenges around identifying ABD effectively and also the medical response to it.

**Positional Asphyxia**

120. I have been referred to a PowerPoint "Operational Safety Medical Implications." (PS18620). This is being revised at the moment. Page 3 outlines the learning outcomes: explain the dangers of positional asphyxia and describe the measures to prevent the same. The content of the PowerPoint reflects the content of Module 4 of the OST Manual "Medical Considerations and Mental Health" (PS18539) at pages 2 to 5. I have been

asked how this PowerPoint is used. This is the OST theory section for new officers taught to them in their initial training. All of the subject specific PowerPoints are for OST theory within the initial probationer training syllabus. The teaching packs outline that, where relevant, when they get to points of things like teaching ground pins or ground-controlling techniques or the use of fast straps, the instructors will repeatedly refer back and identify the risks associated with some of the medical conditions. That's standard practice through the teaching packs and through the instruction, so they don't just get it as a theory input. They get it subsequently around their practical application as well.

121. In relation to positional asphyxia, risk factors are detailed on page 5 of the module, and then signs and symptoms on page 6. There is mention of cyanosis: *"(Lips/nail beds/gums are discoloured) this is a late sign, and often extremely difficult to identify"*. I have been asked if there is any training content about how cyanosis presents in a person with brown skin or black skin. The Department has discussed that with Dr Stevenson, because there are significant operational challenges around that.

122. One of our challenges moving forward in more general terms, but relating to an issue of this nature is how do we equip officers effectively with information that is relevant to them, but importantly that they can apply in the operational environment. Cyanosis is probably a good example of that, and detecting skin pallor in different skin tones is another, because there is a danger an expectation is set of officers to execute skills they are unlikely to be able to apply in the operational environment.

123. There was significant discussion as to how we articulate to officers complexities around issues of skin pallor, to the point where, in conjunction with Dr Stevenson, we developed a form of words on the issue. We've put in

a note around this for the latest release of the first aid notes currently in service which says:

> *"Officers and staff are briefed that skin pallor recognition may not be reliable in detecting hypoxia in different skin pigmentations and light conditions and should not solely be relied on as a sign in determining the patient's condition."*

124. We think that's a practical and relevant explanation to make to officers, because there are other signs and symptoms that are assessed as more effective in the operational environment. We don't wish to create a circumstance where we may be holding officers to a standard that is unreasonable given the operational circumstances.

125. By way of further explanation, in discussion with Dr Stevenson it was established that varied circumstances can affect an officer's ability to detect cyanosis: weather conditions such as rain; the light conditions; if it is at the end of a large confrontation; if the person is actively struggling at the time. All of these operational factors that need to be considered carefully when we provide guidance to officers. This is one of the key reasons why we're undertaking such a large review of the manual and the associated learning material. Additionally, we also have to take a realistic approach to what can be achieved in the training time that we give to our officers and what can be reasonably recalled after a period of time away from training with significant cognitive load, along with the potentially significant physical load in a circumstance where threat risk and harm is high.

**ABD**

126. In the PowerPoint "Operational Safety Medical Implications." (PS18620), ABD is covered at pages 9 to 12. Again, the content of the

PowerPoint reflects the content of Module 4 of the OST Manual "Medical Considerations and Mental Health" (PS18539) at pages 6 to 8. The causes of ABD are outlined slide 9 of the PowerPoint. It says, *"Cocaine is the best-known cause of drug-induced ABD, but other drugs are equally likely to cause it."* This line doesn't appear in the manual. I have been asked whether this is accurate in terms the suggestion that "other drugs" are as likely to cause ABD as cocaine. I can't speak to this, but I can say the content of any updated slides will be put to Dr Stevenson for review as slide content will be developed as a result of any changes to the relevant OST Manual Module that he suggests as the Force Clinical Governance Advisor.

127. We should however again recognise that, in isolation, a large list of causes may be considered ideal, but in the operational environment, when faced with an individual perhaps suffering from ABD, we should be realistic in what our expectations are around the amount officers will recall, depending on how long since they were last trained, and the impact of the operational environment they are working in. So, whilst we provide the best information we can, we have to temper our expectations around officer performance in respect to this. I think we would be challenged to find an officer who was perhaps, say, six months from their re-certification training who could give you a list of 7 causes or 13 signs and symptoms of ABD. So whilst we continue to reinforce key training messages like these, again, we are realistic in our expectations of officer performance given 2 training days a year are allocated to Operational Safety Training and the associated Operational First Aid program.

128. I have been referred to slide 12, "Management of subjects with ABD," which states *"attempts at verbal de-escalation are unsuccessful."* I have been asked whether officers are trained that they should attempt de-escalation, even if it is likely to be unsuccessful. Officers are trained in de-escalation techniques, and we talk about the opportunities to attempt de-escalation, but I

think again we need to put it into context. As I have outlined earlier in my statement to be able to attempt de-escalation, a number of circumstances have to be in place. There has to be a safe environment to be able to physically do that. The incident has to be of a nature where there is discretionary time available for officer to undertake de-escalation and not of the nature where the threat presented may require immediate intervention, There has to be an ability to make contact with our subject and for the subject to engage in communication.

129. There can be a perception that officers either use force or they de-escalate, when the circumstances are more complex than that. So, again, whilst officers are trained to attempt to de-escalate, there are factors around time, space and subject behaviour, before and at the time of the incident, and the ability for the officers to maintain safe tactics that wrap around that issue of de-escalation. So whilst officers are trained as part of their de-escalation package to attempt de-escalation, we have to situate that in context where de-escalation may or may not be possible. In my opinion, it would be too simplistic to say, "Use force or de-escalate." It's a much more complex picture because the circumstances may be such that the officers are not able to, and we should recognise that.

130. A subject exhibiting symptoms of ABD, would be an example of a challenging circumstance to attempt to deescalate. It's not to say attempts wouldn't be made where officers are safe and able to do so but, depending on the environment, depending on the subject actions, depending on the time and space available to officers, depending on what they understand of the threat and risk around the subject, we need to be realistic as to the potential successes or otherwise of an officer's ability to de-escalate in that circumstance. If an officer is required to use force to restrain an individual, their obligation is to then continue to try and de-escalate that incident and

communicate effectively with the subject when they're able to, when the operational conditions allow them to.

131. Context in this area is important because there is a school of thought that you de-escalate or you use force. That's not the case; it is more complex than that, and the conditions need to be set effectively for officers to be successful with the limited training that they have, faced with the cognitive pressures and physiological pressures they are operating under.

132. Management of a subject with ABD also includes containment, where safe and possible to do so and consideration, where possible to alternatives to restraint.

133. Specific operational guidance is provided in the OST Manual that highlight the following in managing a subject suspected of suffering with ABD:

*'If safe to do so, subjects should be permitted comparative freedom of movement within a given area, in what would be regarded as a 'contained' situation • Consideration must, if possible, be given to alternative options to restraining a subject, who is suspected to be suffering from acute behavioural disorder, whilst still affording an appropriate measure of protection for the subject, officers/staff and the public'*

**Restraint and ABD**

134. Slide 13 outlines that:

- *"Subjects who appear to have this condition should be restrained only in an emergency; restraint should be the minimum necessary, and for the shortest practical duration to facilitate transfer to definitive care*
- *Immediately after the subject comes under physical control, they should be placed onto their side or into a sitting, kneeling or*

*standing position. Prolonged restraint in the prone position must be avoided*

- *Observe the subject's condition continually whilst they are being restrained"*

135. I have been asked about the requirement to observe the subject's condition continually while they are being restrained. Module 4 of the OST manual at page 8. This states *"Officers/staff should observe the subject's condition continually whilst being restrained, as death can occur suddenly and develop beyond the point of viable resuscitation within seconds rather than minutes."* It continues in a further bullet point *"Whenever possible during restraint, a 'safety officer' should be identified, their responsibility will be to monitor the health and welfare of the subject during restraint."* Every officer has a responsibility for the care and wellbeing of the subject, and one of the reasons we're so keen to emphasise that is because officers are in different positions at different stages of any restraint to be able to note conditions of the subject.

136. We have to caveat around practicality here as there may be circumstances where all officers need to be actively involved in the restraint because they haven't gained control. It would be challenging, firstly, to require an officer to then step out and act as a safety officer. It's not really practical to do that because if that's the case the officer would be required for the restraint. The fact is the officers sometimes are required to actively engage in the restraint to make it as fast, as efficient and effective as possible, so that the subject isn't being restrained for an extended period of time. It undesirable to have circumstances in which, for example, say three officers are involved in a restraint and that the three of them are struggling to gain control of the subject, and one decides they're going to step out and be the safety officer, this could result that the subject restraint could be longer and cause the subject more risk. I understand how this can be applied

effectively in a more controlled environment where restraint is planned, such as in a custodial setting, where it is less likely staff involved in the restraint are engaged in reactive thinking. However, our officers will more often be involved in circumstances where that level of control and planning time is not afforded to them.

137. I think, again, we run into a challenge around reactive versus complex thinking: the ability for officers to be able to think in a complex manner when they're actively involved in a restraint, particularly, say, if they've been injured or colleagues have been injured and they are already struggling to get control of the subject. In my opinion, it is a challenge to expect an officer or officers to think clearly enough to be able to disengage from a subject where they and their colleagues are actively trying to engage in a restraint, having perhaps already faced violence with the risk of that threat continuing to be present. I'm not sure it's operationally a smart thing to do because it does potentially extend the restraint time.

138. So whilst, as you can see in our manual, we discuss the appointment of a safety officer where practical, where operationally relevant, again, as we look to revise our manual, we would want to look critically at phrases like that to say, "Are we being honest enough and clear enough here about the practicality?," knowing that officers will potentially be held to account for that (noting that being held to account for use of force is both desirable and reasonable). We do want to create conditions however where officers are held to account based on what is reasonable in that circumstance.

**Personal Experience of encountering subjects with ABD**

139. There are two occasions on which I have encountered an individual that I assessed as likely suffering from ABD. One was an edged weapon subject, a spontaneous edged weapon presentation, where my colleague and

I turned up to what was the scene of alleged disturbance to find a male with his shirt off, blood on his chest, with a large carving knife, trying to swing it at a crowd. Once he was subdued we got him to hospital. He was subdued for a period of time at scene but calmed down significantly at hospital. At a point subsequent to this he became hyperaggressive, angry and violent towards my colleague and I, required significant restraint again on the floor of the hospital waiting area. I noted he was extremely hot to the touch, and highly resistant.

140. The information we had at that stage was that he'd ingested a significant amount of cocaine at that point in time up to the incident, and so for me that started to trigger warning signs and concerns around the fact that he may be suffering from ABD. Fortunately, I happened to be in the A&E waiting for him to be assessed, so we were able to flag that to the charge nurse immediately, who was able to then manage that incident.

141. The second occasion was similar. I was involved in a restraint of a male who again had subsequently, as we found out, ingested a significant amount of cocaine. Whilst we were restraining him, the officer that I was working with at the time, highlighted to me, "he is boiling hot to touch." Again, it's probably the most common sign and symptoms that officers will identify because it's physical and tactile, around the potential to identify acute behavioural disturbance factors at scene, and so we were able to convey that to ambulance and ask for an expedited attendance at that point in time, and again just look to enact those practices that we know help to mitigate that around minimising restraint, keeping airways open, continuing to monitor the subject who's still actively resisting at that point in time, getting him onto his side and minimising our contact with him.

142. I'm not a doctor, and myself and my colleagues can only go with what we observe at the scene, but we had heightened awareness from training of what this might look like and might present, and immediately summoned medical assistance because our training was then and still is now that this is a

medical emergency that requires that support. In neither of those incidents was I affected by injury or fatigue, however it wasn't until the subject was under control and the situation stablised that my colleague and I were able to recognise the signs and symptoms. I did not recognise them whilst involved in the active restraint at scene.

143. There is a perceived disconnect in respect to the response Police Scotland receives from Scottish Ambulance Service in respect to responding to officer reports of possible ABD and both us and SAS have commenced work on this specific issue.

144. I have been asked to explain about this perceived disconnect with the Scottish Ambulance Service. The challenge is that when officers communicate this to ambulance service, either through the control room or directly from scene, as is the new alternative model of contact, the current ambulance triage sift may not recognise this is a medical emergency, and it may end up being effectively categorised as a mental health incident. That doesn't necessarily mean an ambulance is going to attend as an emergency response.

145. Police Scotland has concerns about that and SAS are currently working with us on how officers can receive the right response based off what they're seeing in front of them. That will involve, from our point of view, working with officers to make sure they can effectively communicate clearly to ambulance service key words and aspects around ABD that will allow ambulance service to be able to effectively triage an incident such as this, and give us the response that we expect a medical emergency would require, with ambulance service sending an ambulance as soon as practical to a scene such as this. From an SAS point of view it will likely entail modifications to their triage sift and updated training for their controllers.

146. At this time there are incidents where officers are identifying where they believe acute behavioural disturbance may be a factor, and they're not getting the response that we would hope and expect from ambulance service. We know this because we ask officers to complete casualty treatment reports whenever they provide first aid now to a subject, and the officers will identify for us any issues that they've encountered around SAS when something like this arises. That casualty treatment reporting has been in place for approximately 18 months now.

147. We're keen to see the issue resolved definitively and we assess that sometimes officers will perhaps misidentify this, but our view would be, we would prefer our officers err on the side of caution, irrespective that sometimes it may mean that ambulances are deployed to us, and perhaps the incident is not as it seems. But if the officers as non-clinicians are identifying signs and symptoms, then I would hope and expect that those would be taken seriously and that ambulance service would be responding in a manner that would treat the matter as an emergency situation, as we would.

**Restraint Generally**

148. I have been asked what is taught to officers about restraint generally and particularly in terms of the application of weight and/or of pressure to the subject during restraint, the number of officers who could be involved, the length of restraint, the use of a safety officer or an officer to monitor breathing, the risks to life which may be caused by the restraint. There are no limitations placed on officer numbers to be involved in a dynamic restraint. Albeit in the more controlled custody environment we teach a two person violent person team tactic which can be supplemented by others are required. This also includes the use of a safety officer during planned restraint where they are available. We teach a two person model as the baseline model as there are areas where Police Scotland operate where there may only be two officers on duty at the time to engage in the restraint.

149. I don't think it would be reasonable to place a restriction on how many officers can be involved in a restraint because we can't predict the set of circumstances or articulate a limitation based off the impact factors present potentially in an incident scene. In our model moving forward (as explained we're revising the model at the moment) we would aim to use as least officers as possible to restrain as effectively as possible and get someone controlled as quickly as possible, recognising the reality of operational challenges.

150. That's why we teach officers mitigating measures. It's why we teach officers what to do to try to prevent any injury to the subject. Irrespective of their size, weight, height, officers can only work to their skill level in applying the techniques that we teach. We look to teach techniques that are simple, that are as effective as we know they can be based off our own research and national and international benchmarking.

151. Our new model of training emphasises how officers can work together to do that more effectively, and the overarching goal is faster, safer restraint. As I mentioned earlier we do refer, when it comes to restraining a subject with ABD, about identifying safety officers, but we're cognisant again of the practicality of that. We're cognisant of the fact that an officer who's engaged in actively struggling, or officers that are engaged in actively struggling, with a subject may not have the cognitive ability at that time to recognise that requirement.

152. We're cognisant that if you get a third officer on scene, that third officer may need to be otherwise engaged in keeping a crowd away from officers, or indeed have to be involved in supporting the officers because they've not been able to successfully restrain the subject. That's not to say that we would not seek to be able to do that where possible. We are just realistic as to understanding where that may not be possible, and so what we would caution

against is absolutism when it comes to setting rules and frameworks around what officers must do, because we have to be conscious of what officers can do given the set of circumstances.

153. This is the same in respect to being absolute as to where the weight of the officer should be during a restraint. It's not reasonable in my opinion to suggest that an officer will never end up in a position during a restraint where their bodyweight is not on the subject in a manner that causes risk. The dynamic nature of incidents, the reactions of officers to subject actions and the varied impact factors precludes this. It is reasonable in my opinion however that we continue to make officers aware of the risks associated with restraint (as we do now when we are demonstrating and having officers undertake practice).

154. Equipping officers with tactics, techniques and procedures that allow them to rapidly restrain a subject and ensure that they mitigate against these risks is where we continue to drive our service. The current iteration that is being rolled out over the last month focuses on how we support officers engaged in multiple officer restraint to rapidly secure a subject, and that syllabus direction will continue.

155. I have been referred to Module 6 of the OST manual "Empty Hands" (PS18541). I have been referred to page 6 which states:

> *"Holds & restraints are used to control a subject, however, if the subject is put in the prone position, the officer/staff executing any of the following techniques will need to decide what tactical option is preferable to them under the circumstances (such as disengagement, a shoulder ground pin/side ground pin).*
>
> *Officers/staff must be aware of the dangers of positional asphyxia and injury potential when taking a subject to prone."*

156. This Module details various holds and restraint techniques. I have been asked whether it's a matter for officer's discretion as to which hold or restraint to use in the particular circumstances they face. Yes that's correct.

157. Grounds pins are details at page 16 to 18 of this Module. I have been asked to confirm whether ground pins are a specific form of restraint in which the subject is essentially "pinned" or pressed to the ground. Yes, that is correct. I have been asked if there is any guidance regarding this length of time a subject can be held in this type or restraint or in any restraint more generally. No, and again it would be unrealistic to give guidance because, firstly, the officers will not have a sense of time. It's unrealistic to expect the officers engaged in a confrontation to have a real sense of how long is passing, so to give a time guidance I think would be ineffective, in that the officers will not be able to sense the passing of time, but also impractical based off the impact factors about how long it may take to restrain an individual.

158. Our focus is best placed on rapid, effective restraint whilst we do our best to monitor the subject condition and mitigate for any issues around things like positional asphyxia and the effects of acute behavioural disturbance, and other injury for that matter as well, to the subject.

159. I have been asked whether the guidance regarding the appointment a safety officer to monitor the subject is contained in the restraint training within Module 6. No. Our position with regards to general restraint is that all officers are to maintain an awareness of the subject's wellbeing, and it is indeed their responsibility to remain aware of the subject's wellbeing. Again, I caveat that against some of the practical challenges in and around that of whether it is reasonable or practical in a dynamic set of circumstances to be able to identify and appoint a safety officer, as opposed to areas like the custody environment or specific instances around circumstances like acute

behavioural disturbance, because you would hope and expect that where you have an planned restraint, that that restraint will be as quick as possible.

160. However, it is mentioned, as I have explained, in relation to subjects with possible ABD, the safety officer concept does also appear in module 9 about Violent Prisoner Teams. The technique that we articulate involves a two-officer restraint. If a third officer is available they can be used as a safety officer, and it articulates the role of the safety officer with regards to that.

161. I have been referred to Police Scotland's Position Statement 8 (SBPI-00358) at para 53. This states: *"A key addition to the programme was positional control of a subject on the ground, intended to maximise the safety of officers/staff and the subject themselves when being restrained on the ground. Specifically, during 'Ground Control: Subject Face Down', the position of the lead officer/staff prohibits opportunity for others acting in support to place themselves across the body of the subject, which could otherwise increase risk of positional asphyxia."*

162. I have been asked if this this is the technique which is demonstrated in Empty Hands module 6 (PS18541) at page 21. Yes, that appears to be what the technique is describing. From the photograph, what you see there is the officer has hip-to-hip contact with the subject, so what the officer is not necessarily doing is putting significant pressure on the subject's chest or abdomen. The focus of the technique is hip-to-hip contact. By hip to hip contact, I mean, officer 1, has his hips level and pressed against the subject's hips to be able to keep the subject hips pressed into the ground to minimise restrictions on abdomen or on chest. To be clear he is not sitting on the subject, the officer is actively managing their weight through thigh and leg control. It's not a static position. The officer is actively managing the subject, as he would need to be because the subject is likely resisting at this point in time. You can see there's a second officer positioned to secure the legs, so

you've got a leg restraint, a hip restraint, which are two key points to be able to keep the subject on the ground without necessarily putting excessive pressure on the subject's upper body. It also allows access to secure the subject's arms to potentially stop them pushing up, when they need to.

**Current OST Recertification Training**

163. I have been asked how many hours are spent on OST recertification training. It's 16 hours split over two days. There's a theory component, a practical refresh of selected techniques, and a scenario-based training element. There is a detailed breakdown of the time spent on each aspect of the recertification training at pages 14 to 66 of the Teaching Pack National Recertification 2 day course document (PS18569), which is currently being revised.

164. I have been asked how long is spent on training in relation to subjects who are intoxicated due to drink and drugs, experiencing mental health crisis, experiencing ABD during recertification.? The recertification training model is not a theory-based model. It's a practical model taught through the morning on the training mats in accordance with the primary survey.

165. Our annual recertification period for operational first aid is three hours and 30 minutes, and it reviews and allows officers to practice all elements and interventions aligned with the primary survey. The content is included in the operation First Aid manual (PS18581). However, it's recently been enhanced around a number of different techniques to support what we know our officers will encounter around catastrophic bleeding, use of AEDs, penetrating chest injury and hand over of a casualty to ambulance. The updated lesson note version was released in March 2023 but the latest update is dated September 2023. For positional asphyxia, we'd expect them to spend 10 minutes going through the factors alongside signs and symptoms of positional asphyxia and

the management of the casualty at risk of positional asphyxia. The same with ABD: we'd expect them to spend 15 minutes of the three and a half hours discussing common signs and symptoms of ABD, focusing on the behavioural and physiological identifiers and discuss the most appropriate management of the casualty experienced ABD once control is established.

166. The operational First Aid manual (PS18581) was current as at October 2022 and dated May 2021 does not refer to the removal of fastraps or handcuffs during CPR. I have been asked whether the more recent updated version provided any guidance in relation to this. Yes, we specifically put into the training notes about the removal of handcuffs and that was as a result of the Inquiry. This is an example of us trying to continue to learn lessons as the Inquiry progresses, and whilst we're cognisant that the information that the Inquiry received was that it may not have had an adverse impact, we felt that it made sense to be able to put it into the syllabus and into the new training note. In the current, updated training notes, under the section entitled Cardiopulmonary Resuscitation it states: *"If your casualty is wearing handcuffs, these should be removed where practical."* I have been asked whether there is any requirement to remove fastraps. It doesn't say anything about fast straps at this time; however at the time this issue was raised with the department we were not directed to consider the issue of fastrap removal. I'd would seek to take advice from Dr Stevenson on the potential impact of fastraps.

167. It does perhaps illustrate a good example of the realities of operational stresses that officers work under. It would perhaps seem that it would be common sense to take handcuffs off, but when you're placed under those type of operational stresses, some of those things that we would expect and perhaps take for granted in a sterile environment become more challenging to access cognitively in a more difficult operational environment.

168. I am comfortable with the concept of removing fastraps in that circumstance but it would be right and proper to ensure I consult with the Clinical Governance Advisor on the issue.

169. OST recertification training is a two day package that commences with operational first aid for the first quarter of the training They then move into the OST theory and subsequently technique practice and scenario based training for the remainder of the two days.

170. Medical considerations within the OST recertification such as ABD, positional asphyxia etc are reinforced in the context of the practical training. This is also covered where relevant in scenario-based training, where we discuss relevant medical conditions as a potential debrief issue, but any time we revise a technique where there's a medical or health and safety consideration that would be a relevant time for that instructor to highlight that to students. Ground-based techniques are a good example; any time we're moving a subject into a prone position, – the instructors would take the opportunity to reinforce any medical considerations or concerns at that point in time.

171. Having experienced teaching it myself but also having experienced watching a number of my trainers do that, it's a consistent practice. It's an aspect that, during the operational safety training instructors' course, instructors are assessed on as well. If they miss those teaching points, that's a critical error as part of their instructor training and they do not pass that phase of assessment. We expect our instructors to be able to identify the health and safety risks, both the training environment risks and the operational risks, as part of their instruction on any technique. It's part of the assessment criteria for operational safety training instructors when they do their instructor training.

172. I have been asked whether the CUTT principle is revised as part of the recertification training. Yes, the CUTT principle is revised as well as the principles around tactical positioning and the risk posed by edge weapons.. Recertification also refreshes the techniques in the manual, but they've been modified in the latest program refinement to make the teaching of them more dynamic and realistic. But they're taught in every recertification. With each recertification package covering the management of edged weapon threat.

173. Profiled offender behaviour and officer response in accordance with the tactical options model is also covered every year, in every recertification. Restraint techniques are also covered. One of the challenges for us in delivering only a 16 hour training package is that the manual is quite long, and not all techniques can necessarily be covered. In reviewing our two-day recertification package and the package in general, the intention is to continue to consolidate down. Less needs to be taught, and what is taught needs to be as consistent as possible across the syllabus to encourage better retention and more repetition in practice. The level of complexity continues to need to be reduced in order that it doesn't preclude its application under operational stress.

174. It's a large programme to review, weed out, reduce the amount of content we teach to try and make it as relevant, as consistent and as applicable as possible, and as safe as possible. It involves significant consultation, including with our force clinical governance advisor, when we're looking changing techniques. The revised program focus is on allowing officers to be able to work better together in cooperation, developing skills though training drills and mixed with scenario-based training as we move through.

175. I have been asked how recertification training is assessed. There's an assessment criteria, a minimum set of standards that are required to be met,

both in first aid and operational safety training techniques, plus a qualitative, general assessment of competency through instructor observation, but every officer has an assessment grid for Operational Safety techniques that is filled out by the instructor based off, what they see and get tested on at the end of day 2. I have been asked if officers are tested on the theory as well as their physical abilities in doing the technique. There's no theory test as part of the operational training recertification. It's a practical assessment.

176. I have been asked about the use of a rendezvous point (RVP) as a tactical option, particularly in response to a report of a person on a public road carrying a knife. I am conscious that I do not wish to stray outside of my area of expertise into the conduct of incident management training which is the purview of probationer training colleagues. I will seek to frame my answer to this in terms of operational safety.

**Tactical Options – RVP**

177. I've already discussed the challenges of a containment for unarmed officers against a potential edged weapon subject. So whether there is two, four or six officers at scene, the risks posed to them by an edged weapon subject are significant. So, whilst I understand the concept of an RVP in this instance, I guess my question would be, to what end and what would be the outcome of that tactical option?

178. Perhaps it might be to make a tactical plan, but again, I'm not sure the plan would necessarily be different given the limited options available to officers when required to deal with edged weapon threat whereby the location of a suspect is not confirmed.

179. I have been asked about the risks of using an RVP. The use of an RVP would be circumstance dependent. The risks of its use would have to be

assessed against the known risk at the time based off the call information received. There will be a risk the subject escapes or makes off or can't be located. I think one of the key issues would be, are we meeting our obligation to the public in order to effectively attend the call at the earliest opportunity and to protect the public? I guess there is a risk to that, but there are times when we might decide that an RVP would be an appropriate tactical option. To provide a more reasoned or complete opinion I would need to be privy to full incident details.

**Tactical Options - observe, wait and feed back**

180. I have been asked about the use of observe, wait and feed back as a tactical option. Again, observations are a tactical option and, again, depending on the circumstances, may or may not be reasonable. They're most often used during incidents when consideration has been given to the deployment of armed officers. In the context of an individual reported to be in a public road carrying a knife, it is a tactical option. The officers will be looking to weigh up the risk of losing the subject and having the subject continue to be at large and pose a risk to the community versus their ability to observe, wait and feedback. The viability of this option would also be predicated on other tactical options being available to them in a suitable timeframe. So, it is a tactical option and, I think realistically, we need to weigh it against the exigency and the threat posed by the subject to members of the public based off the information that the officers receive.

**Tactical Options – De-escalation**

181. I have been asked what is taught to officers about de-escalation. The subject of de-escalation is taught both in initial training and in recertification training. Module 3 of the OST manual "Tactical Communications" (PS18538) covers de-escalation at pages 10 and 11. The principles listed focus on

physical aspects of an officer's behaviour, remaining calm, the tone of voice, body language, choice of words and the demonstration of respect for the subject as well as some basic safety advice. Principle 14 concludes *"Officers/staff should trust their instincts. If they assess, or feel de-escalation is not working, then **STOP**! officers/staff will know within a few minutes, if it is working or not."*

182. There is a specific powerpoint on de-escalation for probationers which contains similar content outlining a definition for de-escalation, advice for officers and basic operational safety guidance whilst attempting to de-escalate. (PS18562). This content will be further revised once the relevant chapter of the manual has been reissued in early 2024.

183. I have been asked about the consideration around de-escalation being a reasonable tactical option for response to an individual reported to be carrying a knife on a public road. I have outlined my detailed considerations for attempts to use de-escalation of a subject armed with a lethal weapon earlier in my statement and those considerations remain relevant in this circumstance.

184. It is important to be clear in our understanding that there will be times when officers will need to use force and gain control before necessarily engaging in de-escalatory behaviour. There will be incidents where the perception of threat and risk requires officers to act. Now, again, that's not to say that in doing so they don't employ de-escalating behaviours and I would expect and hope they would, particularly once the subject is under control, to help deescalate the set of circumstances.

**Scenario based training – Probationer training**

185. I have been asked how much time is spent on conflict management in scenario-based training is in the probationer training programme? Officers

received 100 minutes of conflict management training during their theory training day and 9 hours 45 minutes of scenario based training content within the probationer training program spread over two days.

**Scenario Based training within the recertification programme**

186. I have been asked about the scenario based training within the OST recertification programme. In the theory package of OST recertification, we cover conflict management, de-escalation and communication skills. For each scenario there is an expectation that the officers will be observed and debriefed on a number of key aspects of their performance including areas such as tactical positioning, tactical options selection and execution, and the use of tactical communication skills.. That's part of the standing debrief package that we brought in this year to ensure that it tactical communications skills in particular are observed and debriefed, because it's an important aspect. That includes not just pre-incident, but during and post-incident reviewing how they effectively communicate with the subject.

187. At the moment, over the two day recertification training course, there are four different instructor lead scenarios run at different parts of the day. The actual subject within the scenario is an instructor and the person leading the scenario is an instructor. The debrief is structured and led by the instructor afterwards. In terms of the officers themselves, it's not just the officers who are participating in the scenario that are involved. Officers from the group observing are also pre-nominated to identify and focus on different aspects that they then peer debrief and provide their thoughts on what they've seen. One of those peer debriefing aspects is tactical communications and de-escalation.

188. The whole subject of conflict management, tactical communications, de-escalation is under significant review right now, working with our force

negotiators. We plan to spend more time on these areas as it can be allocated to us.

**Limitations of Training**

189. There will be limitations on what can be realistically achieved if officers train in Operational Safety only two days a year. That's a challenge not limited to Police Scotland that is the national (and international) training model, but accordingly, if that's what police services are seeking to invest in this type of training, then we do have to temper our expectations of performance. This is why I'm always cautious when I hear the term "officers are trained in". Well, they might be, but how long ago? How regularly are they practiced? What's our expectation of performance, in particular under fear induced, cognitive & physiological pressure?

190. I use the comparator with my armed policing colleagues, for instance, who undertake refresher training once every five weeks. For unarmed officers, we look to do it once a year for two days. Now, we should not expect that investment in training time to generate perfect performance and, in fact, we probably should readjust significantly our expectations around what's realistic given the training time allocated.

191. We know, from academic research, the impact of skill decay. We know the impact of cognitive loading under stress for officers. We should be very cautious about looking at a manual or at a training pack and expecting a replication of that performance under the highest levels of stress. I think it's crucial that we frame the our expectations accurately around what is a reasonable training and performance outcome. Consideration requires to be given to the depth of the challenges around things such as cognitive load, physiological load, operational stressors, skill decay and training time. Skill decay is from the point that training is given to officers, they'll start to forget it.

They'll struggle to recall over time the theory and their ability to physically perform the techniques will lessen, and that's from a relatively low starting base if we accept that we train only two days a year.

192. We have received permission to trial a monthly Operational Safety training model with officers in a two area commands in early 2024. Its never been done before in the UK to my knowledge, but we want to assess the impact of that on training and performance outcomes and see if we can get a better outcome for subject and officers. There are wider resource challenges to a model of that nature should it be rolled out across the service and we have sought to develop a test model that limits or eliminates officer abstraction from their daily place of duty. Despite the challenges of adopting such a model more widely it is my opinion it is worth testing to improve the expected performance of officers with respect to these skills.

**Miscellaneous**

193. I have had sight of Inspector James Young's supplementary statement (SBPI-00362). I have been referred to paragraphs 69:

> *"I have been asked whether I have concerns about the current OST training programme. I think that OST Training to officers still can be significantly enhanced and improved. In my view, it needs meaningful scenario-based training. Public order, firearms and taser training have meaningful, valuable and properly resourced scenario-based training. All the academic research indicates that this is how the training of this kind should be done. In my opinion, we are still falling well short of putting officers into meaningful scenario-based training which are instructor lead. Having recently completed my annual OST refresher, I noted that, although there is a theory input that covers de-escalation, there was no practical elements or scenario/situational based training to practise was what delivered in the theory lesson, or no practical*

*training in tactical/ conflict resolution/de-escalation skills. The only practical training received was technical practice of control and restraint techniques. We were provided information around the signs and symptoms of ABD but no information was provided around the management of someone who is exhibiting signs of ABD. I think this is a risk."*

194. I was aware of Inspector Young's comments and whilst I understand his concerns I don't share them. Police Scotland has just completed the first phase of a revised Operational Safety Training syllabus which, with Inspector Young having not been in the department for 3 and a half years, I would not expect him to be privy to the detail of the current or planned changes. These changes include a reduction in syllabus content, a simplification of techniques, increased drills to improve retention and technique linkage, a drive for consistency across technique selection and the development of team based arrest techniques to enhance arrest effectiveness and safety. They also include a renewed emphasis on consistent, scenario based training supported by instructor and peer debriefing practices (which include the use of tactical communications and de-escalation).

195. I can understand how Inspector Young may have come to his conclusions however, as he will be aware of the challenges to Operational Safety Training delivery over the last two years posed by pandemic training suspensions, the delays in launching the 2 day training model, the pandemic recovery period and as a consequence of the above, the delayed roll out of scenario based training. Inspector Young subsequently alerted me to his concerns after he provided his supplementary statement to the inquiry.

196. It is important to note that all scenario based training within the current operational safety training program is instructor led as well as resourced with instructor role players for safety and enhanced scenario control by the lead trainer.

197. I was concerned about Inspector Young's comments from that time however, as they did not reflect my own experiences of both teaching on OST recertification since my own qualification as an instructor as well as observing multiple courses and I investigated the course he attended at Jackton. I discovered that the instructors on that course delivered two live scenarios and delivered a third 'talked through' by instructors. This is less than I would expect in the program. I was however made aware of the presence of a National Firearms Instructor on the course whom was interviewed and considered the NDM based debriefs provided by instructors to be of good quality.

198. Inspector Young did though attend a single course of over 1000 we have conducted to date over the training year and I don't consider his experiences representative of the training we deliver at this time, and particularly not since the revised training package roll out over October 2023.

199. That being said earlier in 2023 in order to continue to improve the quality of scenario based training, given its relatively new position in the syllabus, I issued a further memo outlining expectations for scenario based training conduct and subsequently an aide-memoire for conduct to ensure greater consistency over the national training locations. The Department takes its commitments to continual improvement seriously and actively seeks opportunities to correct issues arising or indeed, further enhance training quality.

200. I do agree with Inspector Young that additional resources such as those being rolled out in England and Wales to support increased training fidelity around scenario based training would be desirable and the department has already bid for funding to procure equipment of this nature to use in the upcoming monthly OST trial in 2024.

I would welcome further funding to roll this equipment out to all of the training locations across the country however I am also conscious of the challenging financial position the service is presently contending with and understand that the Department may need to be innovative in its approach to increasing scenario based training fidelity in the current climate.

201. I have also been referred to paragraphs 70 and 71 of Inspector Young's supplementary statement. This states:

> *"The way I envisaged the new 2-day refresher course was that it would be inclusive of all the techniques on day 1 and day 2 would be all the instructor lead scenarios, that way you can train officers in tactical positioning, conflict resolution and de-escalation properly. The operational first aid was to be taught separately. However, when the refresher training was increased to 2 days, half a day was allocated to first aid. So officers are not getting much more time in refresher training than they were originally prior to this change.*
>
> *I think the public would be concerned about the lack of training that officers have in resolving conflict. Under the Peelian principles, police officers should use force after persuasion has failed. If you look at the ECHR, force should be the last resort, and unfortunately, I still don't think we have that in practice."*

202. I have been asked for my comments on this and whether I consider that more time is required for OST recertification training as recommended by Inspector Young. In my time in my previous appointment and throughout the period as Head of Department I have not encountered any proposal to extend Operational Safety Training to 2 full days, whilst breaking Operational First Aid out into a third day.

203. The most recent Operational Safety Training refinement in October 23 emphasised the importance of tactical positioning in conjunction with a revised and progressive training program that incorporates a developmental and incremental approach to scenario based training. It reduced technique numbers and made those that are practiced more consistent, cognisant that an increase in training time was not an option that was able to be explored due to operational pressures. I can only presume (quite understandably given his current appointment) that Inspector Young was not aware of these revisions when he made his comments.

204. As you would expect as the Head of Department I would welcome any additional time to train officers in Operational Safety Training, though I consider more regular, periodic training would likely be a better investment that simply grouping two (or more) days together (and breaking out a third for operational first aid) in order to increase retention periods.

205. However since the time when Inspector Young was leading the department Police Scotland has reduced its head count by some 1600 officers and went through a significant period of training suspension due to the pandemic whereby on return to training delivery recertification of those officers whom had not received any refresher training for that time became a priority.

206. Resource pressures such as this are the reality of seeking to deliver optimum training of any type in the time that be can abstracted from operational deployments. It's the Department's job to ensure we make the best of the training time we can be afforded and to continue to develop novel solutions to overcome inherent limitations caused by limited training time and frequency in order to retain Police Scotland's Operational Safety and Operational First Aid program at the leading edge of services within the UK.

207. I believe the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

Signature of Witness November 15, 2023 | 11:08 AM GMT .....Date.....