Wednesday, 29 November 2023

(10.03 am)

LORD BRACADALE: Good morning, Dr Stevenson. Would you raise your hand and say the words of the oath after me.

DR RICHARD STEVENSON (sworn)

Ms Thompson.

Questions from MS THOMSON

MS THOMSON: Good morning, Dr Stevenson.

Is your full name Richard Stevenson?

A. It is Richard John Stevenson.

Q. And you are a consultant in emergency medicine at Glasgow Royal Infirmary.

A. Yes, that's correct.

Q. You're also lead medical advisor to Police Scotland?

A. Yes.

Q. Doctor, in front of you there is a blue folder and if you open that up you will see it contains a copy of a statement that you gave to the Inquiry, that's reference SBPI00390. We will maybe bring that up on the screen just for a moment. Do we see from the front page of the statement that it was taken both at the Royal Infirmary and on Teams during 8 September and 14 September of this year?

A. Yes.

Q. If we scroll to the very end of the statement please,

it's 37 pages long, do we see that you signed the statement -- if you can bear with me just one moment, Dr Stevenson. We have simultaneous transcription of the evidence and it appears that it is a little bit slow and I'm just waiting to see whether it is working as it should be.

(Pause).

LORD BRACADALE: I think, Ms Thomson, you can probably just carry on and we will see how it develops as the day goes on.

MS THOMSON: Thank you, sir.

We were looking at your statement, doctor, which is in the folder in front of you and on the final page we see that you signed your statement on 25 October of this year and you will see on the screen your signature has been redacted, but your signature should appear on the version in front of you?

A. Yes.

Q. And we will see that you have signed every page.

A. Yes.

Q. The very final paragraph of your statement reads:

"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."

A. Yes.
Q. So you understand that your written evidence is before the Chair for his consideration, in addition to the evidence you give today.
A. (Nods).
Q. There should also be in the folder in front of you a copy of your CV. I don't think we need to put that on the screen but the reference is PS18778. And I would just like to say, doctor, that if you would find it helpful to refer to your statement or your CV at any time, please feel free to do so. That's why they're there in that folder in front of you.
A. Thank you.
Q. I want to begin by asking you some questions about your qualifications, memberships and your experience and you provide some detail about these matters both in your CV and in your statement. From your statement and your CV should we understand that you have a Bachelor of Medical Sciences degree in forensic medicine and that you graduated with that degree in 1997?
A. Yes.
Q. And that was from Dundee University?
A. That's right.
Q. That you also have a Bachelor of Medicine and Surgery, that's the MBChB, again from Dundee, and that you

graduated in 1999?

A. Yes.

Q. And that since then you have achieved a Diploma in Forensic Medical Science from the Royal Society of Apothecaries, that was in 2006, and you also have a Diploma in Medical Toxicology from the University of Cardiff and you achieved that in 2008?

A. Yes.

Q. As far as your memberships are concerned, you are a member of the Royal College of Physicians in Edinburgh?

A. Yes.

Q. You are also a member of the Faculty of Forensic and Legal Medicine and a fellow of the Royal College of Emergency Medicine?

A. Yes.

Q. Thank you. You explain in your statement that when you were a junior doctor you were a police surgeon for around two years?

A. Yes, that's right.

Q. What did that work involve?

A. It was care for the prisoners that were in detention by the police and also attending things like suspicious deaths in the community, taking blood samples for drink driving, and sexual assault examinations.

Q. And with the exception of that two-year period, am I right to understand that you have worked in an emergency department since 2003?
A. Yes.
Q. And you have been a consultant in emergency medicine since 2014?
A. Yes.
Q. And day-to-day what does your work as a consultant involve?
A. If we're on the shop floor, the consultant is in charge of the staff that are there for that shift. We make sure that people are being appropriately seen in the time when they should be seen, that blood results or x-rays are being followed up and chased up if there's delays, and you may be in charge of the Resus team where you are there to run the Resus team for people that come in very, very unwell.
Q. And this is at Glasgow Royal Infirmary?
A. Yes.
Q. How many consultants are on duty in A&E at any given point?
A. Four.
Q. How many doctors would be on duty?
A. Oh, probably about 14.
Q. And how many nursing staff?

A. I would say at least 12.
Q. And are you able to give us an indication of how many patients the department might see on a shift?
A. So through a 24-hour period we would see probably around about 240 patients.
Q. 240 in 24 hours?
A. Yes.
Q. Doctor, you also explain in your statement that you are a special constable with British Transport Police --
A. Yes.
Q. -- and have been so since 2013. Can you tell us a little about what that role involves?
A. It's a voluntary role and you have the same powers as a warranted police officer does and you basically get neighboured up or paired up with another officer and then you're tasked to either go to particular train stations to check them for mis -- for trouble, or you may be on mobile response, or you may be on prisoner watch duties, or going out and doing tasks such as delivering a warrant.
Q. How often do you do this?
A. Probably about once every fortnight.
Q. How long would a shift be?
A. 10 to 11 hours long.
Q. You mention that you have the same powers as a constable

when you're on duty. Am I right to understand that you would also wear the same uniform?

A. Yes, it's exactly the same, yes.

Q. So a member of the public, would they be able to tell that you were a special constable rather than an employed police constable?

A. Only if you told them. The uniform is identical to that worn by full-time police officers.

Q. Do you also carry the same equipment as full-time officers?

A. Yes, so baton, cuffs, PAVA spray and other small bits of equipment.

Q. Do you have to undergo the same training as British Transport Police officers?

A. Yes, yes.

Q. Would that include officer operational safety training?

A. Yes, every year.

Q. When you say every year, is that an annual refresher that you have to do every year?

A. Yes, yes.

Q. When you first became a special constable ten years ago, was there the equivalent of probationer training, something of that sort?

A. Yes, there was.

Q. Would that have included OST, as I think it is known for

short, as well?

A. It did, yes.

Q. And there's an annual refresher, as you say?

A. Every year, yes.

Q. When was your last refresher in operational safety training?

A. December 2022.

Q. So you will be due another one before Christmas?

A. Next week, yes.

Q. Who delivers the operational safety training for the British Transport Police?

A. There's two sections to it, so the first section is a PowerPoint or Moodle-type presentation and the second part is a recognised training officer who will guide you through any new techniques or anything to be careful of.

Q. And that's in person?

A. And that's in person, yes.

Q. Do you recall how long your initial training lasted for?

A. For the OST or~...?

Q. Yes, for the OST?

A. It was about a whole day, yes. The refresher is much shorter.

Q. So a whole day initially and how long is the refresher then if it's shorter?

A. About a half a day.

Q. We may return to this later because I might like to ask you some questions about the content of the training that you have undergone recently. Before we leave the subject of your role as a special constable, you said it's a voluntary role, so you're not remunerated as a special constable?

A. No.

Q. What was your motivation for taking on the role?

A. I had become a newly qualified consultant and I felt I needed something to give back to the community. I had done a lot of training for my exams but I felt I needed something for me to be -- to give back to the community but also to do something that was personal to me as well.

Q. Thank you. Doctor, I would like to take your evidence in three chapters. I would like to begin by asking you some questions about your experience of treating patients suffering from a condition known as ABD in Accident and Emergency. I would then like to move on to discuss with you your role as medical advisor to Police Scotland and then finally I would like to look with you at the training materials that Police Scotland used in 2015 and the training materials that they look now with the focus on the training that is given to officers about positional asphyxia and ABD.

A. Mm-hm.

Q. So let's begin then with your experience of treating ABD in Accident and Emergency. It might assist you, doctor, to know that in our earlier hearing on cause of death the Chair heard evidence from Dr Maurice Lipsedge, who is a consultant psychiatrist, and also Professor Michael Eddleston, who is a consultant clinical toxicologist, about the management of ABD from the perspective of a psychologist and a toxicologist respectively. What I would like to do is ask you questions about the management of ABD in an emergency department so that the Chair has the perspective of a consultant in emergency medicine too.

Now, I understand that the Royal College of Emergency Medicine has published best practice guidelines on ABD in emergency departments and I wonder if we could bring these up on the screen, they are SBPI00415.

So we see:

"Royal College of Emergency Medicine best practice guideline."

And if we scroll down the page please:

"Acute behavioural disturbance in emergency departments. Version 2. October 2023."

Am I right to understand that these being produced

by the Royal College, they are in force across the whole of the UK, the guidelines?

A. Yes.

Q. And am I right to understand that you co-authored these guidelines?

A. I was part of the team that developed them, yes.

Q. When were the guidelines first drafted?

A. The group initially got together about a year ago and then we corresponded a lot by email and then only recently in October is the -- was the document finally finished.

Q. Now, this is version 2. I think there might have been previous versions. There was a 2022 version, I think, and maybe one before that.

A. Mm-hm.

Q. Do you recall when the first version --

A. I can't recall, sorry.

Q. All right. Can we look at page 3 of the PDF please. I would like to look with you at the scope of the guidance document. It reads:

"Acute behavioural disturbance (also previously called excited delirium, acute behavioural disorder, or agitated delirium) is an umbrella term used to describe a presentation which may include abnormal physiology and/or behaviour.

"It is important to recognise that ABD should not be considered a diagnosis or syndrome, but rather a clinical picture with a variety of presenting features and potential causes. The term ABD is widely recognised by both in-hospital and pre-hospital emergency care providers, and by the police in the UK."

So if I can pause there, we see that the guidelines state that ABD should not be considered a diagnosis or a syndrome and indeed we have heard evidence that it does not feature in DSM5 or in ICD11. Does that fit with your understanding of the position?

A. Yes.

Q. We have also heard evidence that the Royal College of pathologists have stated that it should not be listed as a cause of death on a death certificate.

A. Mm-hm.

Q. Again, does that accord with your understanding --

A. Yes.

Q. -- of the position? And the guidelines make clear that it is a descriptive term to describe "a clinical picture with a variety of presenting features and potential causes". Again, you co-authored these guidelines, can we take it that you agree with that statement?

A. I do, yes.

Q. Now, there are sections in the guideline on the

presenting features and the causes. However, we have heard extensive evidence about presenting features and causes as part of the cause of death hearing, so I won't take you to those sections, although the guidelines are available for consideration by the Chair.

If we can move down the page a little please to the reason for development:

"ABD patients pose a significant management challenge in the ED ..."

That's just the emergency department; is that right?

A. That's right, yes.

Q. "... when their behavioural disturbance may put them and/or those around them at risk of physical injury, particularly when they have potentially life-threatening pathophysiology such as a hyperadrenergic reaction, metabolic acidosis is or cardiotoxicity. This guideline has been written to support the emergency care of a patient with ABD whose presentation may affect the clinician's ability to ensure that the patient, staff and others are safe, and to achieve appropriate clinical investigations and management."

So the background here is a recognition that patients with ABD present a "management challenge" in an emergency department; would that be fair?

A. Very fair, yes.

Q. Very fair. And that they can present risks both to themselves and to others at a time when their own condition may be life-threatening.
A. That's correct, yes.
Q. And it was against that background that these guidelines on best practice of the management of a patient with ABD in an emergency department were written?
A. That's right.
Q. I wonder if we can look briefly at your Inquiry statement again please and at paragraph 19. At this point in your statement you have recounted an experience that you had with an individual suffering from ABD back in 2014 or 2015 and you were asked if you had encountered any more individuals suffering from the condition since, and you say:

"I have personally been involved in the care of 10 individuals, but there have been more that have been coming through and treated by other doctors. It's not something we're dealing with in the emergency department every week. Maybe every fortnight. I wrote a guideline on how to recognise it, how to treat it, involving safety of staff and patient. The guideline also included treatment medications, those that work and those that don't. I highlighted that it is an acute life-threatening condition, and the important thing is

to get sedation in as fast as possible."

Can I just clarify, the guideline that you refer to there, is that the Royal College guideline or did you also provide a guideline for your own department?

A. It was for the local department.

Q. So you explain at paragraph 19 that you have been involved in the care of about ten patients suffering from ABD over the last ten years but that your department sees a case every fortnight, so there are a large number of cases that come through the doors of your emergency department but you're not directly involved in the care of those patients?

A. Mm-hm.

Q. Do you, however, get to hear about them?

A. Yes, people talk about them afterwards because they often describe just how difficult it is to manage a patient presenting with this condition.

Q. Okay. Of the patients who come through the doors of your emergency department suffering from ABD, what proportion will have been in contact with the police before they arrive at hospital?

A. I would say about 80% have, just as a rough figure.

Q. Okay. The 20% who haven't had any contact with the police, how do they tend to arrive at A&E, what brings them to A&E?

A. An ambulance usually brings them and with family members as well in addition.
Q. Okay. For those who have been in contact with the police, 80% or thereby, you said; of that cohort what proportion come by emergency ambulance and what proportion are brought in in a police vehicle?
A. Most come in police vehicles. So I would suggest that probably 80 to 90% come by police vehicles.
Q. Those that do arrive in an ambulance, are they accompanied by police officers?
A. They can be if the police were involved at the scene. But we have had people present without the police being involved at all and been brought to us.
Q. Sorry, I should have been more clear, so for the patients who have had police involvement before they have been taken to hospital, they may be taken to hospital in an ambulance, they may come in a police vehicle, but those who have travelled by ambulance, having had contact with the police, would there generally be a police officer still with them?
A. Yes, yes.
Q. And of that cohort, those who have had contact with the police before they were taken to A&E, whether they have arrived by ambulance or whether they have arrived in the police vehicle, what proportion are physically

restrained at the point of their arrival at A&E?
A. For the cases I have seen, all of them have been physically restrained using police equipment and officers using their own hands as well to restrain.
Q. So have you seen such patients handcuffed?
A. Handcuffed, yes.
Q. Would that be the norm?
A. Yes.
Q. What about leg restraints?
A. That's pretty much the norm as well, to be honest.
Q. And you have mentioned that sometimes officers will be physically restraining using their hands in addition to --
A. Yes.
Q. -- the equipment having been applied?
A. Yes.
Q. How often are you, or is your department alerted in advance that a person who might be suffering from ABD is en route?
A. Not very often is the unfortunate case, so we rarely get pre-alerted by the police and the Ambulance Service may pre-alert us if they choose to do so.
Q. You say that's the unfortunate case.
A. Mm-hm.
Q. From your perspective as a consultant in emergency

medicine, would it be helpful if you knew in advance, even minutes before, that a person who was suspected to have ABD was being brought in?

A. Yes, because it allows us to prepare the department, prepare a space, a trolley space, and also draw up medications as well so that we can initiate treatment as soon as the person arrives.

Q. Can you help us to understand what proportion of cases where the police accompany the person to hospital -- in what proportion of cases do the police suggest to you that this might be a case of ABD, that there are signs and symptoms that they have recognised and although they're not qualified medically, they have given thought to the possibility that the diagnostic label or the presentation might be ABD?

A. I think in about half the number of cases. When we treat people and say, "This is a case of ABD", some of the Police are quite surprised, being witness to that event.

Q. So when a patient is brought in to Accident and Emergency, a person thought to be suffering from ABD, can you describe their typical presentation, if there is such a thing, in terms of behaviour, mental state and so on?

A. Usually they're shouting out, expressing paranoid

thoughts, or, you know, "Let me out, let me go, let me go". They usually are really hot. You can actually feel the heat off them without touching them as they have generated so much heat throughout the constant restraint and the -- whatever you try to do to say or to communicate with them, they aren't able to comprehend what you're saying because they're in a confused state.

Q. And typically in your experience when they present to A&E accompanied by police who are restraining them, how do they react to being restrained?

A. They're fighting against the restraint the whole time.

Q. As a doctor what sort of impression or impact does it have on you to see a person presenting in that way?

A. It's quite -- I know that some of my staff have said openly that they're quite frightened of what's going on and all of us say, you know, "This is -- that was a really bad one just recently", meaning that it was a really severe case that probably didn't respond well to sedation. So we generally talk amongst ourselves just to say how severe the case was.

Q. So it can be a frightening experience even for a qualified doctor?

A. Yes. Oh yes, yes.

Q. Where within your department will you take a person who is suffering or may be suffering from ABD?

A. So we will inevitably take them to the resuscitation room.
Q. What's the purpose of taking them to the resuscitation room as opposed to another area within your department?
A. The Resus room has more space around each trolley for you to work with your patient. It has a certain set of drugs which are kept in the Resus room, not just sedation drugs but other cardiac drugs, respiratory drugs, et cetera, and it has it all in the one place so we know we can quickly access it if we need to.
Q. Now, before you approach a patient who is presenting in the way that you have described, do you have to assess the risks?
A. Yes, absolutely.
Q. Would that be risks to the patient and risks to staff as well?
A. Yes.
Q. How do you go about doing that?
A. So first of all we speak to the officer -- it may not be the sergeant, but there may be a lead officer that's been in charge of the presentation and we will ask for a background as to what was going on. We will be looking at the staff -- sorry, looking at the patient: are they targeting staff or trying to target staff, are they thrusting about trying to kick, trying to punch or

roll off the trolley onto the floor? So that's what we would do.

Q. Okay. So it's a combination of your own observations and obtaining a history from --

A. Yes.

Q. -- whoever has accompanied the patient into the hospital?

A. Yes.

Q. Can we go back to the guidelines please and if we can look at page 8 of the PDF, that's perfect, there's a section headed, "Managing risk to the patient", and I wonder if we can look at that together:

"Patients experiencing ABD may lose their ability to interact with their environment safely, and their perception of risk may appear non-existent. Patients who are agitated or fearful may or may not react with aggression to others. However, they are likely to react in such a way as to put themselves at risk, especially while attempting to escape a perceived risk, the perception of which may be increased if restraint is applied.

"Patients presenting with severe ABD are likely to lack mental capacity (which should be formally assessed and documented) to make treatment decisions and may require emergency treatment under appropriate

legislation. This may include restraint to allow treatment. Any interventions must be using the least restrictive intervention possible and should be applied for the shortest duration possible.

"Verbal de-escalation should always be attempted. If safe and available, friends and family may be able to assist. Advise on verbal de-escalation is found in section 3.

"Ensure the patient's environment is safe, quiet, and with a minimum of distractions. If they are to be contained within an area of the department (eg to minimise the risk to other patients), ensure that this is minimally restrictive.

"Physical observations and investigations should take place at the earliest safe opportunity. Often this may only be after verbal environmental de-escalation or sedation."

I wanted to ask you just a few questions about this. So the risk assessment guideline anticipates that patients presenting with severe ABD are likely to lack mental capacity and so lack the capacity to give consent to treatment. What does a doctor do in that situation?

A. So we would -- in the initial phase we would treat under common law to try and save the person's life, but we would also, once the dust has settled, put an Adults

with Incapacity Act form in, which allows us then to treat individuals who are delirious for whatever cause and won't be able to understand why they need certain treatments. Some people detain them under the Mental Health Act as well, to keep them within the hospital physically.

Q. So these are legal provisions that will allow you to treat where it's in the patient's best interests?

A. Yes.

Q. In a situation where they don't have the capacity to give consent to the treatment?

A. Yes.

Q. Returning to the guidelines, there's a reference there to verbal de-escalation and we will come back to that in a little while because I would like to explore the role of verbal de-escalation with you in some detail, but beneath the reference to verbal de-escalation the guidelines say:

"Ensure the patient's environment is safe, quiet, and with a minimum of distractions."

Can you help us to understand why that recommendation is made?

A. So things can happen very quickly and the patient may appear to be serene and calmed down but they can suddenly snap back into the behaviours that they had

before, so that's for the safety aspect of it. And the other aspect of it is to try and reduce the stimulus to the patient as well so that the sedation medication that's been given can work and you try and reduce the noise, reduce the lighting, all to reduce stimulation.

Q. Why is it important to reduce the level of stimulation?

A. I think it's important, 1) for the comfort of the patient and also to try and avoid cycling through agitation again when you have managed to calm them down.

Q. The guidelines also say that:

"If [the patient is] to be contained within an area of the department ... ensure that this is minimally restrictive."

What does that mean?

A. So we don't use formal restraints in the NHS and I think it just basically relates to not standing and holding -- physically trying to restrain a patient for an extended period of time.

Q. Okay. So you have explained how you would assess the risk to the patient, it's a combination of history and observations. How would you assess the risk to yourself and to your staff?

A. So I would be -- see what restraint is in place, avoid getting too close to the individual's face so you're not bitten, and if they're not restrained by the police and

they have been brought in by the Ambulance Service we have to make sure that we're not going to get punched or kicked and try and avoid those injuries.

Q. So your patient has been brought in, you have assessed the risks to the patient, you have assessed the risks to yourself. How would you then go about the process of assessing and diagnosing the patient who has been brought to your department?

A. So we have to look at first principles and we will just do a general observation to see if there's anything grossly abnormal, maybe like blue lips, lacking -- you know, suggesting a lack of oxygen, looking to see if they're sweating quite a lot or you can feel the heat off them, and just if they appear to be delirious as well, shouting that people are after them, people are carrying knives, et cetera.

But you have to really go on your sort of gut feel for this. There's no perfect test to say this person is definitely suffering from ABD and it's often with your own experience of seeing it before you would diagnose it again.

Q. So this is a clinical judgment call --

A. Yes.

Q. -- based on experience?

A. Yes.

Q. And you described making visual observations, is the person hot, are they sweating, and you're listening to what they're saying and whether it's delirious or coherent. Do you need to physically touch a patient in order to make this type of assessment, or is it something that you can do at arm's length, as it were?
A. Sometimes we will touch the forehead with the back of your hand to gauge an estimate on the temperature of the patient but trying to get a thermometer probe in their ear or trying to get blood pressure; those kind of observations is nigh on impossible.
Q. Okay, so it's largely a visual check?
A. Yes.
Q. You might be able to touch the person's forehead but you said too you can sometimes actually feel the heat radiating from them --
A. Yes.
Q. -- even without touching them?
A. Even without touching them, yes.
Q. And you're making an assessment as to their mental state too, whether they're coherent or otherwise?
A. Mm-hm.
Q. And I suppose that assessment might inform your view of the clinical picture, but also whether or not this is a person who is capable of consenting to treatment?

A. Mm-hm.

Q. You mentioned getting a history from the police where a person has been brought in by the police. I would like to explore what sort of information you would be asking the police for and there's a checklist in the guidelines so I thought it might be helpful if we began by looking at that and it is on page 6.

Sorry, if we can scroll to the bottom of that page, it's the bottom paragraph:

"The pre-hospital history obtained would ideally include:

"1. Observed behaviours leading to identification of ABD.

"2. Attempts to achieve verbal/environmental de-escalation.

"3. Assessments of mental capacity.

4. Restraint applied, duration and indication.

"5. Security or police involvement, including use of force, controlled energy device use, etc.

"6. Sedative strategy and any adverse events."

So I wanted to ask you about each of these. So a history will include:

"Observed behaviours leading to identification of ABD."

Would that be identification by say the

police officer, or whoever it is who has brought the patient in, and has perhaps told you that this could be a case of ABD, so you would be wanting to understand what had led that person to --

A. Yes.

Q. -- that suspicion? So a history of observed behaviours:

"Attempts to achieve verbal/environmental de-escalation."

Why is it important to you to know what attempts have been made to de-escalate the situation?

A. Because if they have worked in the past, they may work again, but often verbal de-escalation is not successful in these cases.

Q. And again, we will return to the subject of de-escalation in a little while:

"Assessments of mental capacity"?

A. That's -- yes, so assessing their basic functioning, are they able to respond to you when you ask a question, are they hallucinating, are they paranoid, et cetera.

Q. So this would be any assessment made by the police as to that person's state of mind?

A. Yes, yes.

Q. Okay:

"Restraint applied, duration and indication."

Why would it be important to you to know the history

of restraint?

A. So we know how long they have been restrained for because we know the longer someone is in restraint when they're in this state, the higher the risk is for that individual.

Q. "Security or police involvement, including use of force, controlled energy device use, etc."

Why is it important to you to know whether there has been security or police involvement and whether force has been used?

A. It's indicative -- if you're using controlled energy devices then that shows a significant rise in the level of force that's being used to subdue the individual, and that's just basically so that we know that they have had an electric shock via that conducted energy weapon.

Q. Would it also be helpful to you to know whether the person has been physically restrained on the ground, for example?

A. Yes, and whether -- whether they were able to be restrained without handcuffs or with handcuffs and with leg straps.

Q. So would you want to know then if handcuffs had been applied?

A. Yes.

Q. If leg restraints had been applied?

A. Yes.
Q. That's obviously in the situation if they were no longer applied by the time the person reached A&E.
A. Yes.
Q. Would you want to know if the person had been sprayed with CS or PAVA spray?
A. Yes.
Q. Would you want to know if they had been struck with a baton?
A. Yes, absolutely, yes.
Q. And would you want to know where on the body they had been struck?
A. Yes.
Q. And, for example, if they had been struck to the head with a baton would you want to know that?
A. Absolutely because we -- a baton strike to the head could be responsible for causing a significant head injury.
Q. Would you want to know if the person had been brought to the ground and restrained on the ground?
A. Yes, again so that we're not going to miss an injury that may have occurred while the person was in the ABD state.
Q. Would you want to know the position that they had been lying in on the ground?

A. Yes, so particularly whether they were prone or on their side, or on their back.
Q. Would you want to know how many officers had been involved in that restraint?
A. Yes, because that usually gives us an idea of just how serious the ABD is.
Q. Would you want to know how long they had been on the ground in whatever position they had been in?
A. Yes. Again, the longer the person is in ABD as an entity, the worse -- the more serious it gets and we may need to change our approach to the management.
Q. The final point there is:

"Sedative strategy and any adverse events."

What does that mean?
A. So the definitive treatment for ABD is to sedate the patient as a matter of emergency. We -- there are several agents that could be used but all of these have different properties, different times of onset, duration of onset and how they can actually be administered. In most cases, as in 9 out of 10 cases, we would use the drug ketamine as a sedation agent.
Q. Okay, and this is part of the history that you're looking to take from the police. Can you help us to understand what role, if any, you would expect the police to have in a sedative strategy and adverse

events?

A. So we don't expect the police to restrain patients -- we don't -- and then -- or sedate them but if they have come in restrained then we will sedate them and then advise them when they can take the restraint down in a step wise manner.

Q. Okay, so what information is it that you would be looking to obtain from the police here? This is under the heading of "Pre-hospital history". Would the police have anything to contribute, in your experience, in relation to -- that's relevant to your sedative strategy?

A. I can't think of anything just now.

Q. Okay. So there are six things here in this list that you would likely discuss with the police as part of obtaining the patient's history?

A. Mm-hm.

Q. Is there anything else that you would typically be asking the police or want to know from the police that doesn't feature on this list?

A. No, that covers it all, thank you.

Q. Do you ever obtain a history from the patient?

A. You can try but because they're confused, they aren't able to respond to questioning, so if I said, for example, "Where were you today?" And then they will

just start talking about men with knives or, "There are sheep in my bedroom", that kind of thing, so it's just nonsensical.

Q. Okay. Is it your practice to make an attempt to communicate with the person who is suffering from ABD?

A. Yes, absolutely, we do -- we do try. We try and de-escalate but often it is unsuccessful at that stage. But also from a humanity aspect we try and talk to them calmly, try and explain what's going on, saying, you know -- ask them to stop resisting if they can.

Q. And when you make that approach you say that you will talk calmly. What sort of tone of voice would you use?

A. Quite a soft tone of voice and we would go quite near to the patient as well, near to their ear, much more than a whisper but not much more than that, certainly not shouting, "Stop fighting, stop, you know, resisting". We would be saying along the lines of, "We're going to get you better. You will feel better very quickly, we're just going to give you something to make you a bit sleepy", just in common language.

Q. Okay, so common language and you have described reassuring the patient, telling them that you're going to make them feel better.

A. Yes.

Q. And you will give them something.

A. Yes.
Q. What about past medical history? Typically do you have access to the patient's medical notes?
A. It is very important if we do, but sometimes we don't have -- we don't know who the patient is, they have come in as an unknown male -- because it usually -- as every case has been a male so far for us. But if they've got their date of birth and name then usually we can access the person's prior history, see if there's a mental health history, see if there's a substance misuse history or even a previous ABD history as well.
Q. How often do you have the person's name and date of birth?
A. To start with not very often.
Q. I suppose if they come in with friends and family --
A. Yes.
Q. -- they will likely be able to provide that information, but in the cases who are brought to your department by the police, for what proportion are you able to identify that person and call up their records?
A. I think about 50/50 to be honest.
Q. So I was asking you questions about your assessment of a patient who might be presenting with ABD. Are you able to make a clinical judgment on the basis of the presentation, your observations and the history obtained

from the police or potentially family and friends?
A. Yes.
Q. And if the presentation and the history are suggestive of ABD, what are your options, what are the next steps?
A. So the next option is to assess how severe this case is. So one marker for severity is having hyperthermia, high temperature, and we know that the longer the temperature is raised and the actual height of the temperature that's reached, those are indicative of how severe the case is, in which case that would dictate what sedation agents we use. So if that was the case where the temperature was 40 degrees, say, I would be using ketamine on that individual. If it's someone who isn't pyro -- hasn't got a fever, then I would use probably something different, such as an antipsychotic or a Valium-type drug.
Q. Let's talk then firstly about the scenario where the person has a high temperature. Should we understand that your priority in that scenario is to get their temperature down?
A. Yes.
Q. How do you do that?
A. The first thing is to sedate so that -- because the temperature is being generated by the muscle activity and that constant muscle activity raises the body

temperature up and maintains it, so the first thing is to sedate.

We would also strip the patient as well and give them IV fluids that have been in the fridge so they're quite cool and help bring the temperature down.

Q. So chilled IV fluids?

A. Chilled IV fluids.

Q. You said that your drug of choice in that particular scenario would be ketamine?

A. Yes.

Q. Can you tell us a little bit about ketamine and why it would be your drug of choice?

A. So ketamine is an anaesthetic-type drug. Everyone refers to it as the horse tranquiliser but we use it a lot in clinical practice in emergency medicine. Ketamine -- depending on the dose you give, that is the effect that it has on the patient, so we use the first level increment dose of 1 milligram per kilogram for giving pain relief. Then for sedation we would give 2 milligrams per kilogram for sedation. But because in ABD you can't get a drip in and trying to get a drip into someone there is a really high risk of getting a needle stick injury to the staff or the police themselves, plus it probably won't go in either, so we use intramuscular ketamine in that case and we use

4 milligrams per kilogram and then we know from the pharmacology or experience that it is -- just after two and a half minutes after administration it will have kicked in and the person will be sedated.

Q. So in a situation where a person's temperature is elevated you need to arrest the muscular activity?

A. Yes.

Q. And sedation will achieve that effect?

A. Yes.

Q. And you also need to be able to give them IV fluids, chilled IV fluids, to bring the temperature down which you cannot do safely when a person is in an agitated state, so again the sedation allows you to achieve that objective also?

A. Yes.

Q. You have explained that in this scenario you would use 4 milligrams per kilogram of body weight. Are you able to weigh a person or do you use your best guess?

A. It's a best guess estimate, yes. Ketamine has a very good safety profile so if you give a little bit more or maybe a little bit less than you're intending, the outcome is minimal.

Q. You say you give it intramuscularly?

A. Yes.

Q. Typically how do you achieve that with a person who is

presenting in the way that you have described?

A. So we turn the patient onto their side -- and this is where the police often help us as well -- and we inject into the buttock muscle. It usually takes two doses to get the required effect.

Q. If needs be, can you do that through the patient's clothes?

A. We have done -- we have certainly done that, yes.

Q. You say you would turn the patient onto their side; would they typically be on a trolley at this point?

A. Yes, yes.

Q. And should we understand that they would typically also still be in handcuffs?

A. Yes.

Q. And leg restraints?

A. Yes.

Q. And in a typical scenario, if there is such a thing, would you expect the police still to be hands-on in terms of the restraint at that point in time?

A. What we have found in practice is that if you don't touch them as much as possible then that avoids stimulating them and making them more agitated again. So we generally ask the police to step back, once we have given the ketamine, and just let it take its course and hopefully then the patient will be sedated.

Q. Typically do you need assistance from the police to give the person the ketamine injection?
A. Yes, only by holding the patient. It would be medical staff that administer it.
Q. Okay. In the scenario that you're describing in a Resus room in Accident and Emergency, how many medical staff are likely going to be involved?
A. For that case there will be one junior doctor, one senior -- one registrar and probably a consultant as well, and then you will have two nurses present.
Q. We will look at the guidelines again in a moment. They talk about something called rapid tranquilisation. Is what you have just described to us an example of rapid tranquilisation?
A. Yes, exactly, yes.
Q. Let's look then at page 11. "Rapid tranquilisation/sedation". If we look at the second paragraph down:

"Rapid tranquilisation in ABD is important to prevent further sympathetic overstimulation and excessive muscular activity from causing a metabolic storm and subsequent cardiovascular collapse. Rapid tranquilisation can also prevent the patient from causing physical harm to themselves or others and facilitate investigations and treatments. The use of

rapid tranquilisation for more severe ABD presentations is associated with reduced mortality."

And on page 12 please:

"Consider a safety brief prior to parenteral rapid tranquilisation if practicable:

"Roles.

"Intended plan.

"Anticipated problems.

"Restraint considerations.

"Intravenous access plan.

"Plan for moving to resuscitation environment.

"Responsibility for decision to relax restraint."

And then if we skip a paragraph:

"It must be recognised that most sedative agents for ABD have been associated with apnoea, airway obstruction, or a requirement for subsequent intubation (while haloperidol has fewer cases of adverse drug events, it is also associated with fewer cases of successful rapid tranquilisation, and post-haloperidol apnoea has been documented). The practitioner delivering rapid tranquilisation must be capable of managing these complications if they arise. Care of the patient presenting with ABD should be provided by a senior Emergency Medicine practitioner, and early critical care support should be considered."

So I would like to ask you some questions about this part of the guideline. If we scroll back up a little please, the guideline suggests that doctors should consider a safety brief "prior to rapid tranquilisation if practicable". What would be the purpose of this safety brief?

A. It's to reduce the risk of harm to the patient or harm to the staff that are dealing with the problem.

Q. Can we look at each of the bullet points in turn. When it says "Roles", what does the guidance envisage here?

A. So if I was present then I would say, "I'm in charge", and I would direct the team. The other roles would be things like the nursing roles, who was going to be responsible for getting the drugs and drawing the drugs up to us, and who -- which nurse is going to be attempting to try and get a set of vitals off the patient. And then probably a junior doctor as well, not for immediate intervention but once we've got the person sedated then we can look at getting IV access, getting bloods off and doing a ECG.

Q. And we will come on to talk about the management after they have been sedated very shortly:

"Intended plan."

What is that a reference to?

A. That's often -- if we've got a case of ABD and we need

to give ketamine, is everyone happy with that? And usually they are because they have seen -- the staff now are familiar with seeing it and the risks associated with it.

Q. "Anticipated problems."

What problems might you anticipate?

A. So with ketamine because we are using a big dose of ketamine, ketamine can put you into a general anaesthesia and then you will lose your airway, so it's important that we are able to manage that airway, either with adjuncts or even intubating the person and putting them on a ventilator.

Q. Is that why it says, a little bit further down in the paragraph we looked at a moment ago, that:

"It must be recognised that most sedative agents for ABD have been associated with apnoea, airway obstruction or a requirement for subsequent intubation"?

A. Yes.

Q. And the guidelines do also say that:

"The practitioner delivering rapid tranquilisation must be capable of managing these complications if they arise. Care of the patient presenting with ABD should be provided by a senior Emergency Medicine practitioner, and early critical care support should be considered."

So the guidelines are calling for a level of

seniority and you described probably three doctors I think being involved. The most senior would be at what grade?

A. The most senior would be consultant.

Q. Consultant, and a registrar and a junior doctor to provide support?

A. Yes.

Q. "... and early critical care support should be considered."

What's meant by "critical care support" there?

A. That's Intensive Care doctors so we can call on them to come down to Resus and assist us if we -- if you have given sedation and it's not working particularly well, then we have to move down to the second line agent and give an emergency anaesthetic and they can help us with that, either by maintaining the airway or administering a potent set of medications.

Q. And the ABD cases that you have personally treated, have you ever had to do that?

A. I had one. It was particularly distressing for all involved.

Q. If we can return to the points that might be covered in a safety brief, "Restraint considerations"?

A. So if someone has not got any restraint on and we're going to look at giving them an intramuscular injection,

we are going to have to sort of hold the limbs to allow us to do that, but we don't have any physical restraints to do that. If the police are there and the person is handcuffed and Fastrapped, then often it will be we will take those off, once the ketamine has kicked in, and we will let the person return to normal with their movements.

Q. "Intravenous access plan"?

A. Intravenous access, that's who is going to put the cannula in and take bloods off.

Q. So again does this come back to roles and responsibilities and who is doing what?

A. Yes.

Q. "Plan for moving to resuscitation environment"?

A. We always treat in Resuscitation anyway, we don't have it anywhere -- we don't have patients elsewhere in the department due to patient safety and the wider patient safety. And also because, if it does go wrong, then you need to be able to intubate and ventilate that patient and that's only done in Resus.

Q. "Responsibility for decision to relax restraint"?

A. So that would usually be the doctor in charge, so myself, I usually say to the police, "I can advise you now that you can take the restraint off, if you so wish". Ultimately it's their decision, it's not my

decision, but I try and explain to them that it would be better for the patient to take them off.

Q. Okay. Can we look briefly at page 13 please. You have explained that your drug of choice in a situation where a patient has severe ABD indicated to you by a high temperature would be ketamine and under the heading "Ketamine", do we see here:

"In an Emergency Department setting, the use of ketamine as a first-line agent for rapid tranquilisation in ABD is recommended. Ketamine is associated with shorter times to adequate sedation then benzodiazepines or antipsychotics. This should be delivered intramuscularly if intravenous access cannot be obtained safely. This should, if at all practicable, be delivered in a resuscitation environment, by staff capable of managing the complications of ketamine rapid tranquilisation. If administration in a resuscitation environment is not achievable, resuscitation equipment should be immediately available."

So is that very much what you have just explained to us --

A. Yes.

Q. -- about the use of ketamine and the need to have the resuscitation equipment and suitably trained staff immediately available?

A. Yes.
Q. Before we go further and discuss what you would do in terms of management and treatment of the patient after the sedation has become effective, I would like to rewind a little because you said earlier in your evidence that you would give ketamine in a situation where the patient was hot and you considered the ABD to be severe, and that was to bring a halt to the muscular activity --
A. Yes.
Q. -- and to allow you to give chilled IV fluids --
A. Yes.
Q. -- after the person has been sedated. You also said, I think, that if the ABD was less severe you might go down a different pathway. Can you talk us through that?
A. Yes, so not everybody needs basically being put into a dissociative state with ketamine and if the person -- say for example the person is not with the police, they're not restrained, but they're delirious and they're trying to leave the hospital, or they have fallen off the trolley, or they're a general risk to themselves, we will administer different drugs which act slightly slower but last slightly longer, and those drugs would be olanzapine and promethazine.
Q. And how would you administer those drugs?

A. Intramuscularly.
Q. So it's the same process?
A. Yes.
Q. Just a different agent?
A. Yes.
Q. So, once your patient has been effectively sedated, are they alert and conscious, or asleep?
A. So they're in a unique state called a dissociative state, and this is particular to ketamine or other drugs of abuse such as PCP, and the person -- their eyes will be open and they will be looking straight ahead, but they will not respond to you. So we use it to sedate people with broken limbs to reset their legs, you know, their arms, and they don't register the pain at all and they're just sort of staring -- they look ahead and don't respond. That lasts for about 20 minutes and then slowly wears off again. Yes.
Q. And does a person in that state move around or are they completely still?
A. No, they're completely still. They just lie there and look straight ahead and they don't -- you know, you have talked to them but they don't respond to you.
Q. And once a person, your patient, is in that condition, you know the sedation has been effective, what do you do next?

A. Then we hopefully have got some blood tests back to see what we're dealing with, if anything. We continue with IV fluids to rehydrate them because they can lose a lot of fluid through the sweating and then we bring them into hospital, admit them to a -- depends on the level of sedation, so if they're really sick or they have been really -- you know, quite a large amount of sedation, they would go to a medical HDU setting. If, however, it's not that serious and the ketamine has had an effect and they have stopped their agitation, cyclical agitation, then they would go to a general medical ward.

Q. Let me ask you some more questions about that. You said you would hope that you might have had some bloods back. At what point in the process would you have been able to take a blood sample from the patient?

A. Only after the ketamine has been given and the person has entered that dissociative state.

Q. So you would take some blood and what's the purpose of taking the blood, what are you looking for?

A. So we're looking for -- there's a routine set of tests that gets done on nearly every patient that comes through hospitals these days. One would be a full blood count looking for anaemia. More importantly we would be looking at the kidney function because that can be quite severely impaired by the episode of ABD. We would be

looking at the liver function tests to see if there's any damage to the liver. Glucose, which is vitally important because a low glucose level can be a cause for ABD. We would do a set of gases and on that particular test it will tell us how acid the blood is, how much lactic acid is in the blood, which is a marker of severe -- of a severe episode of ABD, and a couple of other small ones that are not pertinent to this.

Q. Okay. Again, let me ask you some more questions about these blood test results. Firstly the full blood count you said you would be looking for things like anaemia, reduced kidney function, liver function and glucose. You take the blood once the person has gone into the dissociative state, within a few minutes, I think you said, of being administered the ketamine?

A. Yes.

Q. How quickly do you get those results back?

A. Within the hour.

Q. So you're not likely going to get that information back during the 20-minute window when the person is in this dissociative state?

A. No, but hopefully when the person has left the dissociative state they will -- they may not be fully orientated to time, place and person, but they generally will be a lot less confused by that time.

Q. Okay. And can we assume that if you identify a problem through the full blood screen, whether it's anaemia or kidney or liver function, or an issue with blood sugar, then there will be a way that that can be addressed --

A. Yes.

Q. -- whether in A&E or on a medical ward?

A. Yes.

Q. And it will depend on what the results of those blood tests are.

A. Yes.

Q. You also mentioned blood gases. Is that blood sample taken at the same time as the full blood count sample?

A. It is, yes.

Q. You said that the one in particular that you're looking for is how acidic the blood is.

A. Mm-hm.

Q. You are looking, in particular, for lactic acid which you described as being a marker of ABD. How does that information assist you as a doctor when you get that result back?

A. So if the blood test comes back showing it is markedly acidotic, which means there is excess acid in the blood, that's a good piece of information to say that this was a severe case of ABD. Also, as well, when the person becomes acidotic they're at much more higher risk of

cardiac abnormalities and then we look at the lactate as well, which is a marker of how much sort of activity has been going on, adrenaline surging round the body, and so we know that the normal lactate level would be 2 or less, but we see cases with 18 or 19, even 20 millimoles in these patients.

Q. Okay. So it sounds as though the results of the blood gas test will give you more information that might tend to confirm that the person has been suffering from ABD.

A. Yes.

Q. Beyond that, if the blood is very acidic, or if there's a lot of lactate in the blood, is that something that you need to treat, or is it just information that helps you manage the patient?

A. It's just information because you have to let the body reset itself back to normal, again by keeping them calm, keeping them sedated. That all allows the body systems to return to normal.

Q. How quickly do you get the blood gas results back?

A. Oh, about 3 or 4 minutes.

Q. You also said earlier in your evidence that during the period that the person is in a dissociative state after their sedation, you said, I think, you will continue with IV fluids. I just want to be clear at what point you begin the treatment with IV fluids.

A. So as soon as you've got the blood out of the cannula, we then will connect up the fluids at that stage to administer probably 1 to 2 litres of fluid quickly.
Q. And presumably you can't do that until the person has become sedated?
A. That's right.
Q. So sedation, followed by the blood samples for testing and the insertion of the cannula?
A. Yes.
Q. And do these things happen at the same time? You have mentioned a number of people being in the room --
A. Yes.
Q. -- or is there a priority of tasks?
A. No, staff are usually working in a team environment and they know to start to get blood -- start to get a cannula in once the ketamine has been given, getting the fluids out and ready to be running through the cannula and someone will run with the gas syringe to get the gases tested.
Q. You said you will give 1 to 2 litres, I think you said, of fluid?
A. Mm-hm.
Q. Is this the chilled fluid?
A. Yes, that's right.
Q. And it's just fluid, it doesn't have medicine in it,

it's just --

A. No, it's just -- it's got salt in it to make it balance to the bloodstream level. If you give pure water it wouldn't be retained within the circulation, so we use a salty solution.

Q. And the purpose of this, you said, was to bring down the person's temperature?

A. Yes, and to replace fluid as well.

Q. And to replace lost fluids. Once you have given 1 to 2 litres, would it be reasonable to suppose that the volume that you will give will depend on the body weight of the patient and perhaps their -- the severity of their presentation?

A. Yes. We will probably continue to give fluids to be honest. In -- the majority of these people are young, relatively fit individuals and they can cope with fast fluids, we would say.

Q. Can I go off on a tangent for just a moment please. You mentioned earlier in your evidence in passing that all of the cases of ABD that you have treated have involved men. Do I understand that all of the cases that you are aware of, that have been seen by your department, have been men?

A. There's a few females in.

Q. A few females?

A. Yes, yes.
Q. But are men very much the majority?
A. Yes.
Q. And you said a moment ago that these people tend to be young and fit, as a generalisation --
A. Yes.
Q. -- would that apply to this entire cohort of patients who have been seen in your department?
A. Most of them. There's one or two patients that have a history of drug misuse and they are in a much worse position there. They've got chronic infection, hepatitis B or C, they're malnourished, et cetera, but the vast majority are young men who have come in after being at a social event.
Q. And these are the young men who you described as being fit?
A. Yes.
Q. And healthy?
A. And healthy, yes.
Q. Sorry, we were talking, before I was distracted by the demographic there, about IV fluids and you have explained the twin purposes of giving the IV fluids: to replace lost fluids and to bring down the body temperature because the fluids have been chilled.
Once the person has been sedated and given fluid,

are you able to monitor their body temperature in a more accurate way than simply putting the back of your hand against their forehead?

A. Yes, we can measure the temperatures, yes.

Q. And is that something you do during the time that they're sedated?

A. Absolutely, yes.

Q. And will that dictate whether you need to give further fluids?

A. Further fluids, or look at other alternatives to try and cool them down. Intensive care units have a machine which can cool somebody down quite rapidly, but we don't have that in Resus.

Q. Would you have the potential of having access to that machine if it was required?

A. I think, yes, if we -- we would probably send the patient up to them for treatment using that machine.

Q. You told us that you would take drugs for gas and for a full blood count. Do you screen for drugs of abuse?

A. No, we don't. The management of people that come in and they have been on drugs, it doesn't make any difference to their management to screen them for drugs of abuse, plus the fact the tests are very -- they take a long time to get done, they're often not very accurate as well and they may have false positives or false

negatives and -- that's for the urine tests for drugs of abuse.

Q. Beyond the management that you have described for us already, is there anything else that you need to do for a patient during the period that they're in this dissociative state?

A. We would generally examine them and look them over. You're looking for any injuries, bruising, even knife wounds in there if someone has been stabbed while in this state.

Q. And you said, I think, that the state will typically last for about 20 minutes?

A. Yes, for the ketamine to have its full effect and settle down.

Q. And can you describe the patient's presentation when they come round from that sedation?

A. They have no memory at all of what's been going on. There's a couple that have still expressed paranoid ideation, saying they have been chased, people are after them, drug barons are after them, but the vast majority just have -- they just then go back to sleep and rest and then wake up in the morning and, you know, anything could have happened to them in that state.

Q. I think you said earlier in your evidence they tend to be more calm --

A. Yes.
Q. -- when they come round. If a person does still have evidence of delusional thinking when they come round, what would you do?
A. We would treat that symptomatically with probably an antipsychotic such as olanzapine because it can be quite distressing that if they have, you know, that fear, that paranoid fear that people are going to come into the hospital, or they may not be orientated to that aspect.
Q. And what proportion of your patients, when they come round from sedation, have continuing disordered thinking?
A. None.
Q. None?
A. None, yes. They all come round and they -- some are seen by psychiatry because of the expressions of paranoid delusions, but most of them go home either the next day or the day after.
Q. Okay. So you said none, so is it a sort of theoretical possibility that somebody could come through and still have paranoid thinking, but in your experience it doesn't tend to happen?
A. I have heard of one case locally in a very sick young man and he unfortunately has not recovered to the functioning status that he was before he took the drugs.

Q. But the majority, you say, come to and go back to sleep and in no time they're home, is that right?
A. And they're home, yes, yes.
Q. Okay. You said earlier in your evidence, when I was asking you about treatment, if you have confirmation through the blood gas results that there's -- that the blood is acidic, do you need to treat that, and you said no, it's really just for information and it confirms that the presentation has been ABD. You said that really it's a question of letting the body "reset", was the word you used, I think.
A. Yes.
Q. And letting systems get back to normal.
A. Mm-hm.
Q. Is that 20 minutes of sedation sufficient to allow the body to reset, or does the process take longer?
A. No, it takes longer. I think you're looking at an hour to two hours before the body resets the level of acidity in the blood.
Q. Okay. So if your patient comes round from the sedation, you have no concerns about delusional thinking, they're perhaps sleepy as you described, would that sort of patient simply go to a medical ward for a period of time?
A. Yes.

Q. And what would happen on the medical ward?
A. They would just get a set of vitals done every -- sort of periodically and they would probably continue getting IV fluids to help flush any toxins out and just generally sleep because it's -- because they have been in such a hyper acute state, hyper aware, they're absolutely shattered and they just need that time to sleep it off and recover.
Q. Okay. In a typical case how long would they likely be in hospital for?
A. Just a day thankfully.
Q. You said typically a patient would go to general medical ward, on occasion they might need to go to high dependency.
A. Yes.
Q. In what circumstances might a patient have to go to high dependency?
A. That's if they've got a significant kidney injury, or they're requiring further sedation as an ongoing administration and that can be done in a high dependency unit, not probably with ketamine again but using a different agent such as a Valium type drug.
Q. You didn't suggest that a patient might ever be referred to a toxicology ward?
A. We don't have toxicology in the west of Scotland. We

don't have a ward, I should say, for toxicology. They do in the east.

Q. Professor Eddleston, who gave evidence at the cause of death hearing, he is a consultant at Edinburgh Royal Infirmary, but we should understand that there isn't that facility --

A. No.

Q. -- in Glasgow. And you didn't mention referring a patient on to a psychiatric ward. Is that something that ever happens?

A. It depends on the patient when they have come round. If they're still expressing bizarre thoughts or delirium then they would be referred to liaison psychiatry, which we have in our hospital, but it's usually not much of a problem to be fair.

Q. If the patient would benefit from input from a toxicologist, what would you do? Is there a liaison facility between the east and west of Scotland?

A. Yes, so we could -- first of all, we can access an online database called TOXBASE, which -- it's great if you know what you're treating and then if there are issues that we were struggling with then we can phone TOXBASE themselves and they have an on call rota and then we can discuss with a poisons expert on what we should do, or if there's anything different we should be

doing.

Q. Yes. I think we heard from Professor Eddleston that he is involved in the procedures that you have just described.

A. Yes.

Q. Doctor, you said that you yourself have treated about ten cases of ABD, that your department sees maybe one case a fortnight, so that's something like 26 cases a year.

A. Mm-hm.

Q. Over what period of time, over the full say nine or ten years that you have been a consultant?

A. So it only really started becoming an issue when the legal highs came onto the scene, or novel psychoactive substances. We never really had an experience of excited -- sorry, of ABD and then the legal highs came on board and we were sort of inundated with people with abnormal behaviours.

Q. When was that?

A. That was probably 2015/2016.

Q. Okay. So that would be eight years ago or --

A. Yes.

Q. -- thereabouts and have you -- has your department seen one case a fortnight, roughly speaking, over that period of time?

A. Yes. I would say so, yes.
Q. Okay. So 26 cases per annum over a period of about eight years. Of those patients -- and you said earlier that the presentation can be quite severe and can be frightening for the doctors involved and these things get talked about within the department.
A. Yes.
Q. How many of those patients died?
A. We have had probably about four or five that have died due to multi-organ failure.
Q. Due to multi-organ failure?
A. Yes.
Q. Can you help us to understand the condition that those particular patients would have been in at the point that they arrived at A&E?
A. So they usually come in and they may be aggressive, but there may have been a history of aggression before they came in and when they come in to us they're lying and they're sometimes not moving at all, but their bodies are rigid. They're extremely hot to the touch and often we have to just get fluids into them as fast as possible, but their kidneys and liver have usually been severely damaged by the ongoing agitation and high temperature before they have come to hospital and then, even though we try to resuscitate them, they

unfortunately don't make it.

Q. Okay. So with the exception of four or five patients who unfortunately arrived at A&E at a point in time where significant damage had already been done to their kidneys and died as a result of multi-organ failure, should we understand that the other patients suffering from ABD who have been treated in your department over the last eight years or thereabouts have sooner or later been discharged from hospital?

A. Yes.

MS THOMSON: Okay. I'm conscious of the time, sir. I'm about to move on to a new topic. I wonder if this would be a convenient point to break?

LORD BRACADALE: Yes, if you're moving on we will stop for a 20 minutes break.

(11.28 am)

(Short Break)

(11.58 am)

LORD BRACADALE: There's been a continuing problem with the realtime transcription so we will just proceed without it meantime and catch up later.

Ms Thomson.

MS THOMSON: Dr Stevenson, I said that we would return to the subject of de-escalation and I understand that the Royal College have something to say about de-escalation

in their guidelines and we will look at those presently but before we do so I would like to look at a paragraph in your Inquiry statement because I would like to ask you some questions about it please. So your Inquiry statement is SBPI00390 and it is paragraph 90 please, 90:

"I am asked if I have ever seen de-escalation work with an individual suffering from ABD."

And just to clarify, is this in the context of treating such an individual in an Accident and Emergency department?

Doctor, sorry, I have gone a little off-script. Your statement begins:

"I am asked if I have ever seen de-escalation work with an individual suffering from ABD."

I was just looking to clarify whether you're talking here on the basis of your experience of seeing such individuals in A&E?

A. Yes, yes.

Q. Thank you. You go on to say:

"Not really. We've tried de-escalation where you try and agree with them and talk them down, and what we find is that you've got this patient that's throwing themselves around on a trolley, or they're restrained and you try and talk to them, and they're just not

registering what you say to them at all. They just shout at you, or they shout 'Get off me. Get off me. Help, Help, Help'. You get a feel for the situation when you're trying to de-escalate. You can tell when it's not going to work and you need medication."

So this, as you have confirmed, is in the context of your experience of treating a person with ABD in an emergency department and you have already given evidence that by the time such a patient arrives at hospital or in 80% of cases, they will have already had contact with the police and they will be restrained, and indeed you refer to such a patient throwing themselves around on a trolley and shouting.

Doctor, in your experience does restraining a person with ABD make them more or less agitated?

A. It makes them more agitated. That's why we try and get sedation in as quick as possible so that we can take the restraint off.

Q. Now, I find myself wondering whether de-escalation might be more or less likely to be successful if attempted at a much earlier stage, perhaps before the restraint process has begun. I wonder if that's something you can comment on?

A. Yes, it would -- it definitely would if you got there early enough to talk the person down, reassure them, but

once they start to cycle up in the agitation phase, de-escalation just becomes less effective.

Q. But even though it might be harder to -- or less effective at that point, harder to de-escalate a person who has been restrained and is already agitated, the guidelines recommend that it be attempted when a person is brought in to A&E; is that right?

A. Yes.

Q. Let's have a look at the recommendation in the guidelines please.

If we look briefly at page 2 of the guidelines which is a summary of the recommendations made, and we can look at recommendation 4:

"All [emergency departments] should have an identified area suitable to provide verbal and environmental de-escalation of ABD cases when required."

So one of the headline recommendations is that there should be a place to allow de-escalation to take place.

Before we go further, can I ask you to help us to understand what's meant by environmental de-escalation?

A. That's lowering the lights, dimming them, trying to avoid noisy -- background noise, alarms on monitors beeping constantly.

Q. Okay. Can we look now at page 10 of the guidelines please. There's quite a lot of information on this page

but what I would like to do, Doctor, is go through it with you. The heading is:

"De-escalation.

"Verbal and environmental de-escalation.

"Verbal de-escalation is a valuable tool with which to facilitate patient care and potentially avoid any requirement for restraint. Staff should make attempts to verbally de-escalate the situation. This may feel futile if a patient will not, or is unable to engage, but is an important step in ensuring that the use of restraint and rapid tranquilisation are justified. A clear record of de-escalation will also provide reassurance to family and the public in cases where an adverse outcome leads to a review."

So there's reference there to verbal de-escalation being a valuable tool and the recommendation that an attempt be made, even where it may feel futile. And would that be your practice, Doctor --

A. Yes.

Q. -- in Accident and Emergency?

And the guidelines highlight that this is:

"... an important step in ensuring that the use of restraint and rapid tranquilisation are justified."

Then:

"De-escalation is a continuous process and repeat

attempts may be appropriate at any point in the patient's care."

What should we understand from that part of the guideline, what is it encouraging practitioners to do?

A. It's avoiding just keeping on giving sedation to quieten the patient down and to try and use verbal methods to calm the person down.

Q. So even if de-escalation hasn't been successful at the outset following the presentation in A&E, there's an encouragement to try it further down the line?

A. Yes, yes.

Q. Let's look at the box that's headed up, "Domains of de-escalation", and perhaps we can talk through the information in this box together:

"Respect personal space. Identify exits. Stay out of arm's reach."

Can you help us to understand what this is saying?

A. This is making sure that you know where the exits are for the room that you're in. Some rooms have two doors to allow you to escape. Other -- like for Resus, for example, that has two sets of doors into the department and stay out of arm's reach so you don't get grabbed or punched.

Q. Okay, so there are some safety considerations there for medical staff. On the left-hand side it says:

"Respect personal space."

Whose personal space would that be; that of the doctor or nurse or patient?

A. The patient's personal space, yes.

Q. And why would that be important?

A. Because they're so paranoid, entering into their personal space can trigger even more paranoia. There would be a -- it's frightening for them as well.

Q. "Do not be provocative. Ensure body language is non-confrontational. Keep hands visible. Do not challenge, insult or engage in argument."

Can you expand on that advice?

A. Yes, so do not be provocative is don't be shouting at them, don't be saying, "I've told you once, get back on that trolley", or, you know, "Put your arms down, I've told you to put your arms down". And then you've got body language is non-confrontational, so you stand -- avoid having your hands up in the person's face, or in an aggressive stance. Keep the hands visible so the person can see them and then do not challenge or insult, that's as it comes across, so ...

Q. Thank you. Why is it important to keep your hands visible?

A. It's so the person can see them and they're not looking as if you're going to sneak behind them or do something

to them that way.

Q. "Establish verbal contact. Avoid multiple staff talking to the patient. Introduce yourself, explain your there, reassure the patient you are aiming to keep them safe."

A. Yes, so establish verbal contact, that's talking to the patient, again in a soft voice and avoid shouting, avoid using long words and technobabble as well, medical speak. Avoid multiple staff talking to the patient, it's much more -- it's much less, sorry, threatening to a person if the same face is there as opposed to multiple nurses or doctors going in one after another, and introduce yourself and explain why you're there and what you're going to do. You can have a go with all that, but often their delirium means that they can't take it on board.

Q. I don't see anything in the guidance about tone of voice but perhaps it is self-evident, you say speak in a soft tone and don't shout?

A. Yes.

Q. "Be concise. Short sentences, give time to respond. Repetition may be needed."

A. Yes, people with delirium are very similar to people with dementia and you may need to repeat the instruction quite a -- you know, two or three times before they will register it as a proper instruction.

Q. "Identify wants and feelings. Identify expectations, empathise."

A. Yes, this is what does the patient want. You know, are they cold, are they warm, are they thirsty, are they hungry. But usually that doesn't work, I have to say. Identify expectations and empathise, you can -- usually the answer is when you ask the question, "What do you want from this?" is, "I want to go home", which is not an option at that time.

Q. "Listen closely. Use clarifying statements"?

A. Yes, so actually listen to your patient when they're talking to you. So if the person says, "I want to go home", you say, "I understand you want to go home but we can't just now", for whatever reason.

Q. "Agree, or agree to disagree. Consider fogging techniques. (Agree with the truth, agree in principle or agree with the odds)."

A. That's -- it's almost like saying be prepared to be -- agree with the truth, agree in principle, but it's being a bit slippery with the information. So if they said, "You're going home now", you say, "Well, yes, you can go home but we will go home in another day's time, or we will go to the ward first and then we will go home". That's the fogging techniques.

Q. "Set clear limits. Clearly inform patient as

'matter-of-fact' not as a threat."

A. Yes, again this is speaking clearly to the patient, again really saying, "You can't go home" or, "Do you want some water? Do you want some food?" That's pretty much what that is.

Q. "Offer choices and optimism. Offer acts of kindness. Offer oral sedative medications"?

A. So definitely offer oral sedative medications if at all possible because that avoids the risk of a needle or an injection. It's not very nice for patients to be held down and given an injection in the bum. Offer acts of kindness -- I'm not really quite sure what that alludes to but I think it just means to basic personal needs.

Q. "Debrief patient and staff. Explain why intervention was necessary. Restore therapeutic relationship. Identify potential improvements."

A. Yes, so this is after the event has occurred and when the person will be saying, "Why am I here?" They will wake up on the ward and have no idea of what's happened to them at all, or they've got, you know, wounds or they have been restrained, so it's just to try and basically talk -- keep them talked down and identify ways of getting the patient back home again.

Q. Now, if de-escalation is successful how would that change the way that you would treat the patient?

A. That's great if they do because it means the person will be staying in hospital voluntarily, they're consenting to getting treatment and they're not having to be held down and injected, or they're not having to be given oral medications to calm them down.

Q. Would they still require sedation?

A. Probably wouldn't at that stage, to be honest.

Q. You said that you have personally been involved in the care of about ten patients with ABD. How many of them were you able to calm down in this way?

A. None from de-escalation. The vast majority of them came in and it was a life-threatening situation so we had to get on and sedate immediately.

Q. When we heard from Professor Eddleston, the toxicologist, during our cause of death hearing, he said in his evidence that typically he would see a patient on a toxicology ward after they had been through A&E -- this was obviously in Edinburgh, I appreciate that there isn't such a ward in Glasgow -- and he said that he will always use de-escalation, although he acknowledged, and I quote from his evidence, that:

"By the time they have come through to us they have generally had some medications so it's not quite such an acute situation."

And in his evidence he spoke about using familiar

language and empathy and remaining calm and I would like to bring up please Professor Eddleston's Inquiry statement which is SBPI00317. And I wonder if we can look at what he had to say about de-escalation at paragraph 46:

"I have been asked to describe the verbal de-escalation techniques I would use when dealing with a psychotic patient. I would use a quiet voice, but one they can hear. Speak in a normal voice. You would ordinarily never yell at a patient. However, we do sometimes yell when thing are going out of control and we're trying to shock them into not doing what they're doing, but generally we try and speak as calmly as we can. We try to always tell them what's going on. We tell them where they are to try to reorientate them. We try to encourage them, telling them that the medicines we're offering would be good for them. We're not getting informed consent for giving them medicines because they do not understand what's going on. I just want the medicines into them because I know it will calm them down. So just a calm voice, keep talking, use language they understand - don't use big words."

Is there anything in that paragraph that you would disagree with or do differently?

A. No, I would agree with what he has said there, yes.

Q. And have you ever had to shout at a patient with ABD?
A. Yes, as a method of sort of shocking them into stop if they're going to punch somebody, but again they don't often take notice.
Q. Can we look at paragraph 47 please:
"I have been asked to describe the body language I would use when trying to de-escalate a situation involving a psychotic patient. I would say 'warm and empathic'. You're aiming to not look aggressive. Sometimes I've seen in hospitals the security guards can be quite aggressive and get in a boxing position when these things are happening, which really doesn't help at all. Actually, I've sometimes asked security guards to leave because they are making the situation worse."
Is there anything in there that you would disagree with or do differently?
A. No, I would agree when he is saying having empathic positions and open hands because a closed hand is quite a threatening stance to have. We have not had any boxing security guards though from what I have seen.
Q. So you have never had to send security away?
A. No.
Q. Can we move to paragraph 50 please:
"I've been asked, in my experience, how successful using de-escalation methods have been in managing

a psychotic patient. I'm not sure. I couldn't say it works in 80% of cases or in 20% of cases. I just know that de-escalation is where we start. There's so much variability between patients. It sometimes works very clearly. I can think of several occasions where it worked really well. Other times, it did not work and we've had to physically restrain people."

Again, is there anything in that paragraph that you might disagree with?

A. Just with the physically restrain. Does he refer to NHS staff restraining the person, or does he refer to other staff such as police?

Q. I'm not sure. I would need to reflect back on his evidence, but perhaps from your perspective you could clarify what you would do in a situation where you felt restraint was required, if indeed that is a situation you have ever been in?

A. Yes, I have been in that situation and it's basically to stop harm to the person, the patient themselves, and to other staff. I just wondered if it -- yes. I just wondered if it was his staff or he had security staff to come along and restrain for him.

Q. I'm afraid I'm not sure, but in the A&E department, in a situation where a patient is accompanied by the police, if there was a need for restraint would you

expect the police to manage that restraint?

A. The police would generally step in at that point and restrain.

Q. And what would you do if a person had, for example, been brought in by family or friends and you felt that there was a need for restraint for their safety, for the safety of someone else?

A. We would have to get a collection of staff in within the A&E to help us, assist us with a specific aim in mind, not looking to just restrain for the sake of restraint. That doesn't serve any purpose at all other than cause distress to the patient, so it would be restraining them to administer medication, for example, and then standing back and watching the effect of that.

Q. And when you say you would bring together a collection of staff, would that be doctors, nurses, or security staff?

A. Doctors and nurses.

Q. And are you trained in restraint?

A. With my police hat on, yes, I am, but not in the NHS.

Q. What about nursing staff in the NHS, are they trained to restrain patients to administer medication?

A. No.

Q. Can we move on to paragraph 55 please.

Professor Eddleston has referred back to his report and

to a paragraph where he states:

"Sometimes the agitation is too great for this approach to work ..."

That's the de-escalation approach:

"... and the person cannot understand the situation or calm down. In this case, the person must be physically restrained to allow rapid and safe administration of intravenous or intramuscular sedative drugs, such as diazepam or ketamine. Duration of physical restraint is kept to an absolute minimal to reduce the risk of complications. As soon as the patient is sufficiently sedated with medicines, physical restraint is withdrawn."

Again, is there anything in that paragraph --

A. No, I agree with that paragraph.

Q. Can we also look please at paragraph 51, where Professor Eddleston was asked if there are any kinds of approach that don't work as well with psychotic patients:

"Being aggressive, making the patient frightened, doing anything to stimulate their fight or flight response, is not going to help. So, you would always find in the hospital that people who are dealing with these patients are trying to be as calm as possible. It's wonderful to watch the nurses with these patients.

They're really calm. They just try to settle things down. They're always talking in a nice voice, trying to get the situation under control, while at the same time someone will be phoning for security and for a doctor in case it doesn't work."

Again, can I just invite your comment on that paragraph?

A. That would be very nice to have a team that in -- where I work as well. We just have to get on and do our best to be honest. We probably don't have the training for de-escalation that these nurses have gone through. But I agree with the overall premise of the paragraph.

Q. Okay. So you would agree that being aggressive, making a patient frightened, stimulating the fight or flight response is not going to help?

A. Absolutely not, no.

Q. I wonder if I might also invite you to look at Dr Lipsedge's Inquiry statement. It's SBPI00298, at paragraph 41 please. He was also asked how he would approach a patient and he said:

"Approaching such a person in a non-threatening way is essential. Some people obviously are better at this than others. Some people have the ability to appear less threatening or more amiable, or less frightening. This involves a person's body language, their way of

speaking to the individual. You'd introduce yourself by your name, say who you are and why you're there, for example, 'the shopkeeper called me because he was a bit worried that you may not be well', something like that, and try and establish a conversation. We try and use both non-verbal and verbal de-escalation; if appropriate try to sit next to the person, offering them a proverbial cup of tea, if that's available, can be very effective. I think posture and how you position yourself in a reassuring and non-threatening way are very important."

Again, can I invite your comment on what Dr Lipsedge said in his statement?

A. Yes, I think that's a very nice example of verbal de-escalation and also watching your body language as well, to avoid being frightening or threatening towards an individual. I would agree with that 100%.

Q. I would like to read to you a very short extract from Dr Lipsedge's evidence, Day 55, page 23 of his evidence. This won't come up on the screen but it's very short, I will just read it out:

"Answer: What I teach medical students is in a situation like that you have to pretend you've got unlimited time. Of course you haven't got unlimited time, but you have to give the patient the impression

that you're able to listen to them and that you're not in a hurry. Now, of course for professional reasons you might well be in a hurry but you have to convey the feeling that you have unlimited time to spend in discussion with the patient."

Again, could I just invite your comment on that?

A. That's not an approach I have heard before but it sounds a nice way to go about de-escalation. But again, when we're in A&E we don't have a lot of time to spend with each patient unfortunately so ...

Q. And in A&E, and in particular when somebody is presenting with what you think may be ABD, can time be of the essence?

A. Time is definitely of the essence, yes.

Q. I would like to move on, before we conclude this chapter of your evidence, to ask you a few questions about pre-hospital care and if we could perhaps bring up your Inquiry statement again please and look at paragraph 62:

"I am asked about pre-hospital emergency medicine. This could be mobilised by the control room for the Ambulance Service. This would be for the pre-hospital service to consider both for the individual and the people around them."

I wanted to ask you some questions about this paragraph, Doctor. Can you tell us about the

pre-hospital service, what does it involve?

A. So I'm not a pre-hospital physician but I do liaise with them when they bring patients in and this is a way of taking doctors, and nurses as well, or a paramedic, to the scene of an incident, or to another hospital to retrieve that patient and bring them back to Intensive Care facilities in Glasgow.

The pre-hospital side of things, they can get primary mobilised by the -- this is -- there's a particular individual, I can't remember his name just now, what his title is, but he is the one that decides whether to send people to -- in the pre-hospital environment or not. Pre-hospital medicine is generally looked at stabilising the patient and getting them back as fast as possible to hospital.

Q. Is it the Scottish Ambulance Service who provide this pre-hospital service or is it a different organisation?

A. It's the Scottish Ambulance Service.

Q. Okay. And I have heard of something called the Emergency Medicine Retrieval Service; is that what you're describing?

A. Yes, so this is the -- that was the first sort of incarnation of the service and they primarily go to hospitals up north or rural areas to retrieve people and bring them back to Glasgow for definitive treatment.

Q. And are they part of the SAS then?
A. Yes.
Q. So you say they would go to hospitals in rural locations. Do they sometimes go to the scene of, for example, an accident that's perhaps not readily accessible and bring that person back?
A. They might do that, or they might be mobilised to an incident within the city centre of Glasgow and they've got a vehicle instead of a helicopter for that.
Q. So they have a helicopter they can use. Do they use traditional ambulances too, or some other form of vehicle?
A. No, they generally rely on helicopters and if an ambulance was needed they would be called separately and they would attend under direction of the retrieval team.
Q. To your knowledge do the -- does the Emergency Medicine Retrieval branch of the Ambulance Service respond to calls about people suspected to be suffering from ABD?
A. Not that I'm aware, no.
Q. If the Emergency Medicine Retrieval Service doesn't provide that facility, is there provision in Scotland for a person who might be suffering from ABD to receive medical treatment at the scene, or is it simply a question of an ambulance attending and, perhaps with police support, taking the person to A&E?

A. It's the latter, so the ambulance staff now have been trained up in the recognition of ABD and what they can do initially to provide any treatment, but they usually pair with the police at that time to take the person to hospital.

Q. You say you're aware that paramedics are being trained to recognise ABD. To your knowledge are there any guidelines, protocols, anything of that sort in place for paramedics or for the SAS north of the border?

A. So there's a thing called the JR CALC(?) which is guidelines and it has got within that about ABD.

Q. And are those guidelines in force across the UK?

A. Yes.

Q. As far as a pre-hospital service is concerned, in your view as a practitioner of emergency medicine, would there be a benefit to a patient in a doctor going to the scene, as it were, where a person is thought to be suffering from ABD?

A. It would because, as we have explored earlier, you want to get treatment into the individual as fast as possible. You want to get them sedated to avoid the cyclical agitation which gets worse and worse.

Q. If one of the priorities then is to sedate a person who is in this state, is that something that could potentially be done by paramedics?

A. They can administer one dose of diazepam as an injection but that involves having to have a cannula put into the patient, so I don't think a paramedic would be able to offer much.

Q. You described earlier giving quite a high dose of ketamine intramuscularly. Is that something that a paramedic could do?

A. No, that would be outwith their skill set.

Q. Okay. And would they even have access to that sort of drug as part of the ambulance kit?

A. Certain paramedic practitioners in the UK have been authorised to carry ketamine to use as a pain relieving agent, not for sedation.

Q. You said earlier in your evidence that with ketamine there is a risk, and this is acknowledged in the Royal College guidelines, that a person may become anaesthetised and you may need to manage their airway and so on. Does that present any particular risk if there was to be a proposal that ketamine be given at the scene to someone suffering from ABD?

A. So it would be -- any anaesthetic being given, you try and have absolute control over the scenario. If you're outdoors, I mean, in bad weather, or there's other people hanging around, then that makes that job of maintaining their airway much more difficult and more

risky.

Q. Have you yourself ever gone to a scene outwith the hospital to administer pre-hospital care to patients?

A. No, I haven't, no.

Q. You said that someone will make a decision as to whether the Emergency Medicine Retrieval Service should be deployed. How would a request for that service be made? Is it simply by calling 999 and asking for an ambulance, someone will effectively make that decision; how would a request be made?

A. I think that initially an ambulance would be deployed to the scene and then they would then radio the control room and say, "This is beyond our skill set, could we have the EMRS team in attendance please".

Q. So should we understand that, as things stand, there isn't really provision for pre-hospital care of a person with ABD in Scotland?

A. Mm-hm.

Q. And the priority is very much simply to get them to a hospital?

A. Yes.

Q. And as far as mobilising a doctor, perhaps even a nurse to the scene, is concerned, an ambulance would attend in the first instance and if the situation was beyond their skill set they might ask for the Emergency Medicine

Retrieval Service?

A. Yes.

Q. Okay. So the gateway to that service then is the SAS?

A. Yes.

Q. And you need an ambulance to attend before consideration would even be given to the Emergency Medicine Retrieval Service?

A. Yes.

Q. Inspector Young, who I believe you know, and I will ask you some questions about your involvement in his work shortly, but he gave evidence last week and he told the Chair about two occasions when he had called an ambulance for a person who he suspected was suffering from ABD and was told by the call handler it wasn't a medical emergency and an ambulance wouldn't be sent.

Do you have any experience anecdotally, through your work in A&E, of ambulances not being willing to attend calls where a person is suffering from ABD?

A. I haven't heard anecdotally myself, no. I have heard -- I have heard the police say to me, "You know, we phoned for an ambulance and they told us they couldn't supply one".

Q. Let's perhaps look at what Inspector Young had to say. Can we bring up his Inquiry statement please, it is SBPI00 -- oh, you're a step ahead of me -- SBPI00362,

paragraph 37 please. So he is describing two incidents where he encountered individuals who he thought were suffering from ABD. At paragraph 37 he says:

"One of these incidents was post 2015/2016 and the other was post 2018. Both of these incidents involved white men. The first one was a disturbance. I wasn't the first on scene but other officers were there. When I arrived, these officers were trying to physically control a male. To me it was immediately obvious that the man was displaying symptoms of ABD. I remember he was incoherent, sweating heavily, constantly in motion, and displayed bizarre behaviour. He appeared scared and panicky as opposed to aggressive. I instructed the officers to let the individual go. We remained close to the individual and called for an ambulance. However, we were advised that the ambulance wouldn't be attending - it wasn't recognised as an emergency. As the individual was next to a busy main road, to prevent further harm we had no other option to restrain the individual. We took him straight to hospital."

So that was his first experience, Doctor, and if we scroll down to paragraph 38 he recounted a second similar experience:

"The second incident was a call regarding a male acting suspiciously. The man was reported to be naked

and he was outside the bottom of a block of high-rise flats. Again, other officers had attended and were there before I arrived. I think there were four officers by the time I arrived at the scene. It transpired that he wasn't actually naked. He was wearing boxer shorts and I could see that his other clothes were lying nearby. The officers were in the process of trying to restrain him. I noticed that he was incoherent, pacing back and forward, and sweating. He was within a large bin area which was three sided. There was no immediate requirement to restrain him. I instructed officers to take a step back and contain him within the bin area. I requested an ambulance. I now can't recall whether it was our area control room or the ambulance control room that refused the request for an ambulance. After containing him for around 10 to 15 minutes, he calmed down to a degree. At that stage we detained him under the Mental Health Act and took him to hospital."

So those were two experiences that we heard about just last week from Inspector Young and we're going to shortly turn our attention to the training that the police receive in relation to ABD, but if the police are trained to contact an ambulance in order to have someone removed to Accident and Emergency and the SAS,

at least on these two occasions, is unwilling to provide an ambulance, then what options are the police left with?

A. The only option is to take the person in the police vehicle up to the A&E department.

Q. From your perspective as a consultant in accident and emergency medicine, is that an ideal mode of transport for a patient in this state?

A. No, I would say most certainly not. You want to be able to keep a constant eye on the patient, like you would be able to in the back of an ambulance. You want to avoid any risk of positional asphyxia which may happen in the back of a cell van. And at the end of the day it's a medical emergency as opposed to a police incident.

Q. Do you have any thoughts as to how the current state of affairs could be improved?

A. I would hope that they are getting improved -- they are improving. I have done some work with paramedics locally to explain about ABD and produce a podcast for his colleagues, but failing that I think there would need to be very high level discussions with the SAS and the Police Service.

Q. Tell us about the podcast?

A. The podcast was sort of an interview scenario and he -- I was asked the questions of what is ABD, how does it

present, how do we treat it, how would -- what would be expected of the paramedic service to treat these individuals, and more just to be aware of its existence more than anything else.

Q. You said you did this locally for some paramedics?

A. Yes, it was locally, yes.

Q. So who will be the audience for this podcast?

A. Mainly paramedics.

Q. Just local or across Scotland?

A. Across Scotland.

Q. And how recently was that?

A. That was about six months ago.

Q. Before we conclude this chapter I want to ask you very briefly about the language, the acronym ABD. We have heard evidence about the evolution of language used to describe this condition. We know that -- or we have heard that excited delirium is no longer used and that ABD is the accepted terminology. Dr Lipsedge suggested another alternative acronym, SAPID, which stands for a seriously agitated person in distress, which he says he would prefer as it is more humanising and it is descriptive. I simply wondered if you had any comment to make on that suggestion?

A. Just that we have campaigned for recognition of ABD to be a physical entity and if we introduce another acronym

again we might lose all the ground that we have covered with that.

Q. Thank you, Doctor. I'm going to move on now to ask you questions about medical advice and clinical governance that you provide to Police Scotland in your role as lead medical advisor. In your Inquiry statement you explain that you were appointed in 2017 and Police Scotland in a position statement have confirmed that the date of your appointment was 3 July 2017. We will look at your terms of appointment and the work that you have done since your appointment shortly but I wanted to begin by asking you some questions about work that you did prior to your formal appointment. If we can bring up your Inquiry statement again please. You explain in your statement that you gave advice to Inspector Young on officer safety training materials before you were appointed, and if we can look at paragraph 5 you say:

"In 2017 I was appointed as lead medical advisor and clinical governance advisor to Police Scotland. At the time I was a member of the working group formulated to address legal highs. I met Inspector James Young there. He told me that Police Scotland struggled to get medical representation on the group and I volunteered my services to provide medical opinion for the group."

You go on to say:

"Before I was fully appointed, I worked with Inspector Young giving advice on Police Scotland training materials, just to check if there was anything glaringly amiss for the training program. I was giving most input into Operational Safety Training (OST). I can't remember if it was First Aid as well because they're combined into one document, so there was some First Aid in the manual as well as [OST] and I think I would have commented on the whole manual provided to me."

So you explain that you were on a working group and that's how you came to meet Inspector Young and that led to you being asked to assist him in the way that is described in paragraph 6 of your statement.

So you explain at paragraph 6 that you would have commented on a whole manual that was provided to you and this was at some point before your appointment in 2017. Do you recall when it was that you were asked to review this manual?

A. I think it must have been around 2015 or 2016.

Q. We heard evidence from Inspector Young last week that he carried out a review of the officer safety training programme and he produced a report in April 2015 and then he went on to develop a new training package that was rolled out in 2016 and he told us that you reviewed

the medical implications section of the manual to ensure that it was clinically assured. So it appears from what he told us that it was likely a draft version of the 2016 manual. Would that fit with your recollection of the timeframe and what you saw?

A. It would, yes.

Q. Do you recall what it was that you were asked to do or what advice you were asked to give?

A. I think it was looking specifically at the effect of legal highs and would their -- would they impact on the police's OST training manual, and also any first aid that would be unique to legal highs.

Q. So were you asked to review the medical implications of the techniques taught to officers during safety training more generally, or was it very specific to legal highs and first aid implications?

A. Initially it was legal highs, as the first review.

Q. You say "initially", was there a further review, or were you involved in advising on a more general basis?

A. More on a general basis.

Q. Okay. Inspector Young's evidence, as I say, and I'm quoting from his evidence here on 24 November, page 116, he said that you:

"Answer: ... reviewed the medical implications section of the manual to ensure it was clinically

assured and to make sure that it was accurate."

Would you accept what you says you did or --

A. Yes, I would accept that, yes.

Q. You say at paragraph 6 you think you would have commented on the whole manual and you say that you were asked just to "check if there was anything glaringly amiss". Was there anything glaringly amiss?

A. Not that I recall, no.

Q. What advice did you give?

A. I think it was just -- I can't quite recall, but what I was looking through was to see if any of the techniques that the police use for restraint would provide -- would be in danger of causing harm to an individual and also the effects of PAVA spray, batons, et cetera, as well, anything that -- anything missing from those particular sections.

Q. Inspector Young in his evidence suggested that you proposed some slight changes to the section on ABD. Do you remember that?

A. I don't recall, sorry.

Q. Would you take any issue with what he said?

A. No, I wouldn't, no.

Q. He also told us that there's a version control log for the manual and a record of changes that were made and who advised the changes to be made, so if we wanted to

know what changes you had suggested in relation to ABD we could perhaps check the version control log.

A. Mm-hm.

Q. But you don't remember anything glaringly amiss --

A. No.

Q. -- when you read through the draft 2016 manual?

So that was prior to your formal appointment. I want to move on to ask you some questions about your appointment as lead medical advisor and clinical governance advisor and if we could scroll down to paragraph 14 of your statement please, so this is lifted from a position statement provided by Police Scotland, and it appears to be your terms of appointment, so let's read through this:

"With respect to physical use of force tactics and operational first aid, clinical governance continues to be provided by the independent Clinical Governance advisor, Dr Richard Stevenson, who was formally appointed as the Lead Medical Advisor on 3 July 2017. The following are the terms of appointment to this role:

"Advise the force on medical issues.

"Where appropriate and necessary develop and maintain operating procedures and procedural guides;

"Quality assurance of the training of medical skills including delivery materials and practice;

"Review significant incidents to identify any required changes in practice, training or equipment;

"Review any complaints received in relation to medical care delivered by police officers;

"Provide a single point of contact for medical equipment evaluation and purchase at the first instance; and.

"Monitor use of medical skills by police staff."

Would you agree that these are your terms of appointment?

A. Yes.

Q. Would they have been confirmed in a letter or some document around about the time of your appointment?

A. I think so, yes.

Q. Police Scotland say in the paragraph above the list of bullet points that you are both their independent clinical governance advisor and lead medical advisor. Now, can you help us to understand the difference between a clinical governance advisor and a medical advisor?

A. So relating to clinical governance, that's an umbrella term which is used to describe when -- it is like an audit process of the delivery of a healthcare service.

A lead medical advisor -- lead medical advisor is my role to say authorise or consider the use of a new

airway technique, or a new piece of equipment for the police to carry.

Q. Are you remunerated for the work you do for Police Scotland?

A. No.

Q. Is there an agreed time commitment, such as so many hours a month?

A. No, there isn't, no.

Q. And how much of your time does this role take up?

A. On a monthly basis I would probably have to deal with two or three emails, but then another month I might end up with six or seven, depending on what's going on.

Q. And how long might it take you to respond to an email?

A. So usually within -- I respond to them mainly about 48 to 72 hours.

Q. Sorry, is that the time within which you respond?

A. Yes.

Q. Rather than how long it --

A. Ah, right, yes.

Q. Sorry, no, that's my fault entirely. I wasn't clear at all. I'm just wondering if you can give us an indication over the course of a month, If you're responding to somewhere between two and six emails, what the time commitment is?

A. Probably about four hours.

Q. About four hours. So maybe about four hours of work a month?
A. Yes.
Q. Now, who at Police Scotland asks you to do work?
A. Mainly I get work -- I get emails from individuals mainly from firearms, from the lead first aid instructor and sometimes other projects that are ongoing at that time.
Q. So there's not a single point of contact, as it were; different people from Police Scotland might contact you --
A. That's right.
Q. -- if they need to call upon your skills and your services. And how do these individuals from Police Scotland instruct you to do work; do they pick up the phone, do they email you?
A. They email me is their first point of call.
Q. And how do you share your advice with them?
A. I generally do a bit of background reading if that's required and then I will send an email back to them.
Q. What I would like to do is look at each of the terms of appointment in turn and discuss with you what you are asked to do to fulfil that term of appointment. So the first is to advise the force on medical issues and you say in paragraph 15 of your statement -- although we

don't need to pull that up -- that you:

"... advise on medical issues, including the content of operating procedures and procedural guides."

And I would like to explore with you how this works in practice. Who might ask you to advise on a medical issue?

A. So, for example, I have had -- I was instructed by an assistant chief constable to assist on a naloxone programme that was being rolled out.

Q. And naloxone, is that the antidote to heroin?

A. Heroin, yes.

Q. What sort of advice did you find yourself giving? I don't mean the nuts and bolts of the advice, but what sort of issues were you asked to advise on?

A. Any risk to police officers using the drug, or risk to the general public and general background to naloxone as an agent. And then I would be -- I was part of a training team that went round certain stations instructing on the use and carriage of naloxone.

Q. And again, how do you receive requests for medical advice; is it by email?

A. By email, yes.

Q. Do you respond by email?

A. Yes.

Q. And when I asked you earlier what your monthly

commitment was and you said it could be a couple of emails, it could be five or six, are these the sorts of emails that you might be receiving and responding to in the course of a month?

A. Yes, yes.

Q. Okay, so when it comes to advising the force on medical issues, you would wait for the police to contact you and seek your advice on a particular medical issue, something like the naloxone project?

A. (Nods).

Q. Let's move on to the next term of appointment:

"Where appropriate and necessary develop and maintain operating procedures and procedural guides."

Is that something you have ever been asked to do?

A. No.

Q. Let's move on to the next one:

"Quality assurance of the training of medical skills including delivery, materials and practice."

Now, can we begin by exploring the language here. What do you understand is meant by "quality assurance", or can you help us to understand what's meant by quality assurance in this context?

A. So, for example, it would be checking a programme of delivery of first aid, for example, looking through the manual, seeing if it -- spotting any spelling mistakes

and seeing that the instructions that are given in the manual are appropriate for the police to be doing in a first aid situation.

Q. Okay. And help us to understand what is meant by "medical skills" in this context, or what you understand it to mean?

A. So it would be, for example, using equipment to provide ventilation breaths to someone who is in cardiac arrest, use of defibrillators.

Q. Can we bring up your statement for a moment please.

LORD BRACADALE: I think this is his statement.

MS THOMSON: I beg your pardon. I'm so sorry. Can we go to paragraph 16. At paragraph 16 you say:

"Where it says 'Quality assurance of the training of medical skills including delivery materials and practice', that is in relation to operational safety training rather than for, for example, first aid. For the first aid, I'm not quite sure what the regulating body is but they have a syllabus. Their lesson plans are designed around that particular syllabus set by health and safety regulations."

So I just want to be absolutely clear, Doctor, that where you're providing quality assurance of the training of medical skills, whether we're looking at medical skills in the context of operational safety, as you say

in the statement, or perhaps whether there's also a first aid element to it, as you suggested in your evidence just a moment ago. Can you help me with that?

A. Yes, I would say that I would be asked about first aid, for example when the COVID epidemic was at its peak there was a change in resuscitation guidance, so it was to discuss with the health and safety lead on changing that.

Q. Okay. So you do provide quality assurance in relation to medical skills in the context of first aid but should we understand that you also quality assure medical skills in the context of officer operational safety training?

A. Yes.

Q. And does that relate to the techniques that are used by the officers?

A. Yes, yes.

Q. Can you give examples of the sorts of medical skills that an officer might learn during operational safety training?

A. So it would be -- they could use face masks to provide ventilation to people who are unconscious and not breathing. They can use automatic external defibrillators. They also have just recently been trained to carry tourniquets and how to pack wounds.

Q. So I wonder again whether those might be examples of first aid techniques rather than operational safety techniques?
A. Yes, I would say that, yes.
Q. Can you give me examples then of the sorts of medical skills an officer might learn during their operational safety. Not the first aid skills but skills to do with the techniques -- medical skills they might apply during the techniques --
A. Oh, I see, yes.
Q. -- that they use in their operational safety training. I'm sorry if I wasn't clear. That's absolutely my fault.
A. So it's the risk of injury after PAVA use, that's the irritant spray. The risks of using a baton and which areas of the body would be classed as a safe target as opposed to a high risk target. Handcuffs and the risks of handcuff neuropathy. I think that's ...
MS THOMSON: Okay, that gives us a flavour.
I'm conscious of the time, sir, I wonder if this would be a convenient point to break?
LORD BRACADALE: Yes, well, we will stop for lunch and sit at 2 o'clock.
(1.00 pm)
(The luncheon adjournment)

(2.02 pm)

LORD BRACADALE: Ms Thomson.

MS THOMSON: Thank you. Good afternoon, Doctor. Before lunch we were looking at your terms of appointment and I wonder if we could perhaps put those back on the screen. They were in paragraph 14 of your Inquiry statement. Thank you. We were looking at the third term of appointment:

"Quality assurance of the training of medical skills including delivery, materials and practice."

And you explained to us that you look both at officer safety techniques, you mentioned the risk of PAVA injury, batons, handcuffs and so on, and first aid techniques such as using face masks, defibrillators, tourniquets and packing wounds.

Before we go any further, there is one matter I would like to clarify with you please. There's evidence before the Chair that there were two different types of first aid training within the police, or there are still two types of first aid training within the police. There's the First Aid at Work three-day course, and there's evidence that the syllabus for that is set by the Health and Safety Executive, and there's a shorter course that used to be called SPELS, it's now called operational first aid, and that's the course that

all police officers undergo. Only a smaller number of officers, including those who go on to deliver officer safety training, are required to take the First Aid at Work course.

I wonder if you can help us to understand whether your involvement in first aid techniques relates to the First Aid at Work course, or the operational first aid course, or potentially both?

A. I would say it was potentially both.

Q. Thank you. Returning to this term of appointment:

"Quality assurance of the training of medical skills including delivery, materials and practice."

There are three parts to that term of appointment: delivery, materials and practice. And I would like to look at each of those in turn.

What is asked of you with a view to you providing quality assurance of the delivery of medical skills in the context of officer training?

A. So I am asked to look at the syllabus that's been provided and look at the training material that has been developed by Police Scotland and review those for being up-to-date with medical practice.

Q. Okay, so you review the syllabus and training materials and consider whether they are up-to-date and in keeping with medical practice?

A. Yes.
Q. Okay. Now, if we look again at the term of reference, it is:
"Quality assurance of the training of medical skills including delivery, materials and practice."
So I can see how the review of the syllabus and the training materials would provide quality assurance of the materials themselves, but I'm wondering what has been asked of you with a view to ensuring quality assurance of the actual delivery of the training that officers within Police Scotland receive?
A. I would say I have not really been involved in that.
Q. Can we go back to paragraph 11 of your statement for a moment please:
"I am asked if I only advise on the written content or whether I am asked for advice on the Police training in practice, in scenario training or practical training for officers. I've been doing quite a bit of scenario training recently with the firearms trainers and the public order trainers. Not so much with the first aid trainers. I've been assisting with the delivery and the training techniques that have been used by firearms and counter terrorism."
And at paragraph 12:
"I have not been hugely involved in the standard

probationer training or recertification training for ordinary constables who may be involved in restraint or dealing with knife incidents. I'm asked to look at a broad overview to see if there's anything glaringly obvious that would be considered a lack of safety, but not a huge amount. They seem to run their own process. I'm not involved in lesson plans. If anything new comes in they will approach me and discuss anything with me over the phone or by email. For example, if talking about applying assisted respiration to a casualty, the face mask and how you use it, how it can be used, how it can go wrong. Areas like handcuff injuries as well. These are all standard injuries and techniques that are taught currently in most police training courses."

So you explain in your statement, Doctor, that you have been involved in training with firearms and public order trainers but not so much with first aid and you haven't been hugely involved in probationer or refresher operational safety training. Have you had any involvement at all in the practical delivery of officer safety training?

A. No.

Q. Okay. Have you ever been asked to sit in on the training that probationers receive?

A. No.

Q. Do you think it would help you in fulfilling your responsibility for the quality assurance of the delivery of training if you had the opportunity to watch that training be delivered and provide feedback?
A. Yes, I believe it would.
Q. How would that help you?
A. So we would look at -- be looking at the delivery, see what information is being imparted, if they're using PowerPoint to make sure the slides aren't too busy and that they are easily legible to people in the classroom. Also, as well, it's looking at the trainers and see that their techniques are up-to-date.
Q. You say in your statement that you have been involved in scenario-based training for firearms and public order trainers. What has your involvement been in their training?
A. So they have a scenario where it could be a man with a knife or a man with a gun and then they have someone injured within the scenario and they have to utilise their skills and techniques to usually address catastrophic bleeding.
Q. And when you were -- you say you were involved in this training. What was your involvement; were you an observer or were you actively involved in the training?
A. I was an observer and I was taking notes to see if it

they were following guidelines such as, you know, addressing catastrophic haemorrhage first, above airway, breathing, circulation, and making sure that they were putting the tourniquets on correctly and they knew about packing wounds to stop bleeding.

Q. Did you give feedback based on your observations?

A. Yes.

Q. Did you find that to be a helpful process?

A. Yes.

Q. And to your knowledge did the police find that to be helpful?

A. Yes, I think they did, yes.

Q. You also say in your statement that you're not involved in lesson plans for operational safety training. Again, do you think it would be helpful for you if you could be involved in lesson plans, if you had that opportunity?

A. If I had the opportunity to look at the development of the plan, yes.

Q. There's evidence before the Chair that as far as operational safety is concerned there's been a move in recent years towards scenario-based training and I wondered whether you would find it helpful if you were involved in devising scenarios for those training programmes?

A. Yes, I think it would be beneficial for me and for

the police.

Q. And what do you think that you could bring to the discussion?

A. Direct experience from managing people with catastrophic injuries, complications that can arise, and generally provide feedback.

Q. If we move away for a moment from the more first aid skills and focus on the delivery of operational safety skills which might have medical implications, such as the cuffs, the batons, leg restraints and so on, again would you find it helpful to be involved in devising scenario-based training for the police?

A. Yes, I would.

Q. For the same reasons?

A. Yes.

Q. Would you find it helpful to watch scenario-based training in progress?

A. Yes, I found that -- especially with the firearms because that was a new concept to me in dealing with individuals that have been shot and the safe -- you know, the scene safety and equipment safety that's involved.

Q. So you clearly found it helpful from a first aid point of view?

A. Mm-hm.

Q. And I'm wondering if it might be just as helpful for you from the point of view of quality assuring the officer safety techniques that are used that have a medical implication?
A. Yes, yes.
Q. And would you find the opportunity to give feedback after viewing that training helpful?
A. Yes.
Q. Okay. Do you think it would assist you to undergo the training that officer safety trainers themselves undergo?
A. I believe it would, yes, because it would give me the opportunity to, for example, you know, have the handcuffs on -- have the handcuffs on and realise the limitations that that has on when you're dealing with a person, and also looking at the effects of PAVA spray as well on individuals.
Q. Is there anything else that you can think of that might assist you in providing quality assurance of the way that training on medical skills is delivered to police officers?
A. Just as we have said, to see the lesson planning and also be in the room when it's being delivered.
Q. If we can return to paragraph 14 and look again at the terms of appointment please. We're still on the third

one:

"Quality assurance of the training of medical skills including delivery ..."

Which we have spoken about:

"... materials and practice."

Let's talk about materials now and if we can perhaps begin by going up to paragraph 8 of your statement. You have explained already, doctor, that you will be provided with material for you to review. At paragraph 8 you are asked:

"I am asked how the process of providing input to the OST manual worked when I was first appointed as the lead advisor in 2017. I had the first meeting with a multitude of different people: police, occupational health and a couple of other specialties as well. We were all involved in Police Scotland as an organisation. We discussed matters at a meeting and then would go away and it would be my job to look through materials that they referred to me. I would read those documents and provide comment and approval or recommendations for change."

So was this a meeting that you went to following your formal appointment in 2017?

A. Yes, it was.

Q. And you describe meeting with the police, occupational

health and others. Did this group have a name?

A. It was just called the clinical governance group.

Q. Police Scotland refer in a position statement to the clinical governance advisory group. Would that be the same thing?

A. Same thing, yes.

Q. Okay. So that was the first meeting of that group that you attended. Have there been others since?

A. Yes, usually on a quarterly basis.

Q. When was the last meeting?

A. That was probably two quarters ago. One has been cancelled -- the latest one was cancelled.

Q. There's a reference in your statement -- we don't need to go to it, but it's at paragraph 126 -- that the group stopped meeting because of COVID?

A. Yes, physically. We were using Teams instead.

Q. I see, so the meetings carried on?

A. Yes.

Q. Just remotely, okay. So how many meetings have you been to since 2017; have you been to them all?

A. I have attended all of them apart from one.

Q. What is the group's terms of reference?

A. I don't have them to hand. I would need to refer to them myself.

Q. That's all right. Are you able to give us an indication

of the sorts of issues that are discussed at these meetings?

A. So it was looking at whether new pieces of equipment that's come onto the market could be used, the latest thing is regarding do not resuscitate orders and what to do if someone is coming into custody with a do not resuscitate order in place, or if the police go to the community and what do they do if a DNR form is there, do they obey that or do they start CPR on their own?

Q. Are you asked to give advice at these meetings?

A. Yes, yes.

Q. Are you asked on the spot, or are you sent materials to consider in advance?

A. It's on the spot.

Q. And how do you provide advice? Is it just in the context of that discussion?

A. It depends on what the advice is. If it's something simple like the carriage of oxygen, that's not too bad, but something like a DNR CPR and the legislation around that and whether police are instructed to follow it, that would require me to go away and read up about it.

Q. And then how would you provide your advice?

A. Via email to the group.

Q. Okay. You mentioned there being the presence of other parties on the group, including occupational health.

A. Yes.
Q. Who is the representative from occupational health?
A. It's -- there's a female doctor and her name escapes me and there are two occupational health staff as well.
Q. Are there any parties represented on the group who are external to Police Scotland, aside from yourself?
A. No -- oh, sorry, I tell a lie, there's a paramedic that sits as a consultant paramedic.
Q. So would they be representing the Scottish Ambulance Service?
A. Yes.
Q. Given that you sit on the same group as the Scottish Ambulance Service, has the subject of conveying persons suffering from ABD to hospital ever been discussed at these meetings?
A. It hasn't, no.
Q. Beyond attending these meetings, what arrangements are in place for you to review materials and provide advice on the content of materials?
A. It would be up to me to contact the relevant sort of single person of contact in the department such as firearms, public order, and there was the naloxone group as well.
Q. Okay. So would they provide you with materials to look at and then you would respond with your comment --

A. Yes.
Q. -- on the materials. You say at paragraph 8:
"We would discuss matters at a meeting and then would go away and it would be my job to look through materials that they referred to me. I would read those documents and provide comment and approval or recommendations for change."
That's something that you would follow up by email?
A. Yes.
Q. And you say that the request to read material could come from firearms, it could come from the naloxone group?
A. Yes.
Q. And we know too through your work with Inspector Young that you have also been asked to review operational safety training materials.
A. Yes.
Q. Now, in paragraph 81 of your statement -- we don't need to go to it, but when you gave your statement to a member of the Inquiry team you said that you had at home a 2017 version of the operational safety training manual?
A. Yes.
Q. And you also said that it was the most up-to-date version that you had until shortly before you were interviewed, I think you were provided with the 2022

version just in advance of your interview. So I'm keen to understand whether you had seen the 2022 manual before you were interviewed by the Inquiry team?

A. No, I hadn't.

Q. And have you been asked to carry out a review of the operational safety training manual since the review that you carried out in 2016?

A. No, I haven't.

Q. You mentioned that there's an occupational health doctor that sits on the clinical governance group; are there any other doctors?

A. No, I'm the only other doctor.

Q. You are the only doctor?

A. Yes.

Q. Do you think there would be any benefit from having any input from other branches of the medical profession?

A. Yes, I think it would be helpful, yes. Depending on their background and what their specialism is.

Q. What specialisms do you feel might bring value to the work of the group?

A. So a mental health specialist or psychiatrist.

Q. Anything else?

A. I can't quite think at the moment, sorry. I can't think right off the top of my head. Even another emergency medicine doctor so it's not just me on my own.

Q. And what would be the advantage of having a second emergency medicine doctor?
A. It just acts as a checks and balances approach.
Q. Do you know whether there is an equivalent group in England and Wales?
A. I know that every force in England and Wales have been advised to have a clinical advisory group, clinical governance group.
Q. And is there any liaison between the clinical governance advisory group set up by Police Scotland and equivalent groups in England and Wales to your knowledge?
A. There's been, within the last six months, a generation of -- a meeting of people from the clinical governance groups in England and Wales and Scotland as well.
Q. You say that's been within the last six months?
A. Mm-hm.
Q. Before that were there any such meetings?
A. No.
Q. And was there any liaison with your counterparts south of the border, as far as you know, if we go further back that six months?
A. No, there wasn't.
Q. Do you think there would be a benefit to the Police Scotland clinical governance advisory group of drawing on the experience and expertise of colleagues

south of the border?

A. Yes, I think there would, yes.

Q. Can we look at paragraph 126 of your statement please:

"I have been asked to explain how I normally work with Police Scotland in terms of providing advice on the content of manuals and other training materials. It is mainly done by email correspondence. The modules are emailed to me, I look over them to see if there's anything that needs to be changed from a first aid point of view and submit them back. I sit on a clinical governance group. It stopped because of COVID but I think it meets quarterly. There's a vast array of representation around the table on occupational health, training, Police Federation, normal policing and ACC Williams who chairs the group. We discuss things there. Sometimes Police Scotland have done a piece of work and then think that they need the clinical governance team to look over it. It might not have any input of clinical governance until the very end of the project. That probably isn't the best if you need to make changes."

I'm interested in what you say at the very end of that paragraph, that the group might not have any input until the very end of a project and, "That probably isn't the best if you need to make changes". Can you

expand on that and help us to understand the sort of situation that you had in mind here?

A. If, for example, they were going to introduce pulse oximeters to measure oxygen levels in the blood, then usually what happens is an officer does a briefing for it, looks into the costings of it, and then it would be passed to me after all that's done to comment on it and see what I think, or what's my opinion of the equipment, when really at the start I could be advising them what type of equipment is best suited for themselves, you know, from a costing point of view and also from an efficacy point of view as well.

Q. So do you feel there would be a benefit to the clinical governance group and to Police Scotland perhaps as a whole if the clinical advisory input was sought at an earlier stage in the process?

A. Yes.

Q. Can we look at paragraph 10 please:

"I am not presented with the materials yearly and asked to review them. It's usually up to me to see if anything is new or has been introduced through developments in medical understanding that could be considered for First Aid purposes in Police Scotland. They may come to me with requests, but it's my responsibility to say if there's anything major that

requires change."

So you say it's your responsibility to alert your colleagues in Police Scotland if there's anything major that requires change; in practice how do you fulfil that responsibility?

A. Again through email to known individuals in the groups.

Q. Do you think it would assist you in fulfilling that responsibility if you were asked to carry out a periodic review of materials, and I have in mind in particular here the operational safety training materials, perhaps on an annual basis or something of that sort?

A. I think that would be helpful, yes.

Q. We heard evidence from Inspector Young just last week to the effect that it's his opinion that there would be merit in having a wholesale review on an annual basis. Would you agree with that?

A. I would, yes.

Q. So returning to paragraph 14 please and to the terms of Dr Stevenson's appointment, we were looking at the third:

"Quality assurance of the training of medical skills including delivery [which we have discussed], materials [which we have discussed] and practice."

What are you asked to do to provide quality assurance of the practice of medical skills by serving

police officers?
A. So I have been watching them delivering CPR, looking at the physical aspects of the procedure, applying a defibrillator, utilising airways to keep someone's mouth open, and recent introduction of the eye gel to public order medics.
Q. So that all relates to first aid.
A. Yes.
Q. I'm wondering whether you have been asked to provide quality assurance of the practice of medical skills by officers in the context of operational safety training, so the restraints, handcuffs, things of that sort?
A. No, I haven't.
Q. Can you think how you might go about that task?
A. It would be easy enough for me to do. I would just write to the -- or email the individuals that are responsible for it and ask them to -- if I could come along and observe them.
Q. But that's not something that so far you have been asked to do --
A. No.
Q. -- by Police Scotland? Would you find that helpful?
A. Yes.
Q. Do you think it would help you to fulfil this term of reference?

A. I think so, yes.
Q. Let's move on. The next term of appointment is:
"Review significant incidents to identify any required changes in practice, training or equipment."
What have you been asked to do with a view to fulfilling this term of reference?
A. I have not been asked to do anything for that particular term of reference.
Q. The next term of appointment is to:
"Review any complaints received in relation to medical care delivered by police officers."
And again, what have you been asked to do to fulfil that term of reference?
A. I have not been asked to do anything.
Q. Moving through the list:
"Provide a single point of contact for medical equipment evaluation and purchase at the first instance."
And I think you explain in your statement, at paragraph 15, if we scroll down just a little, that you do that, you:
"... provide a single point of contact for medical equipment evaluation and purchase. [Such as] tourniquets, or oxygen monitors, oxygen cylinders, who can carry them, what the risks are."

And you reference again the naloxone training that you have told us about in your evidence?

A. Yes.

Q. And scrolling back up -- thank you, that's perfect. The final term of appointment is to:

"Monitor use of medical skills by police staff."

What do you understand "staff" to mean in the context of this term of appointment?

A. This would be police -- this would be employees of Police Scotland but not police officers.

Q. And what have you been asked to do to fulfil this term of reference?

A. I haven't been asked to do anything.

Q. Doctor, I would like to move on to the third and final chapter of your evidence now which will require us to look at the officer or operational safety training materials from 2015 and those dated 2022 and I would like to go through these with you with a particular focus on the training delivered in relation to two subjects: firstly, positional asphyxia, and secondly ABD. So I would like to look at positional asphyxia first. We will look at the 2015 materials, then the current materials, and then we will carry out the same exercise for materials relating to ABD.

So let's begin with what was the training manual in

place at the time, the officer safety training manual, it's PS10938 and if we could start with the first page of that manual please we will see it is copyright 2013 Police Scotland and in the bar at the right we can see that I think it says, "Student training manual". It does indeed, thank you.

We heard evidence from Inspector Young just last week that this was the central reference point for probationer training and should also have been used for refresher training after September 2013.

Can we move forward to page 29 please. I should say, Doctor, that I appreciate that in your role as clinical governance advisor to Police Scotland you will not have been asked to look at the materials that were in place in 2015. However, the Inquiry has an interest in the materials that were in place at that point in time.

So, "Medical conditions and considerations", and if we scroll down a little we see, "Positional asphyxia", and there's a definition offered:

"Positional asphyxia (restraint related asphyxia) can occur when a subject is placed in a position which interferes with the ability to breathe. Death can occur rapidly and it may be the case that a police officer can be found to be liable."

Is there anything in that paragraph that you would take issue with, doctor?

A. No, I think that's accurate.

Q. Okay. There then follow a list of risk factors which contribute to the condition:

"Subject's body position results in partial or complete airway constriction.

"Alcohol or drug intoxication ...

"Inability to escape position.

"The subject is prone.

"Obesity.

"Age.

"Stress.

"Respiratory muscle fatigue, related to prior violent muscular activity (such as fighting with police officers)."

Do you wish to make any comment on that list of risk factors?

A. No, I would say that's pretty inclusive. There are some extra causes of asphyxia such as crush asphyxia, where pressure on the outside of the chest is being applied, for example people that have been in a landfill -- a land slide or in the Hillsborough disaster where people were crushed together that way.

Q. Can we look at the first of the risk factors:

"Subject's body position results in partial or complete airway constriction."

Is there anything that you might wish to say about that?

A. This is a risk factor that's applicable to police officers when dealing with individuals. So, for example, in the back of a cell van.

Q. At paragraph 38 of your statement -- and what I will do is I will read this to you so that we don't have to jump between documents. We will just leave the risk factors on the screen. I will read this out, Doctor. Of course you have a hard copy in your folder that you can refer to at any time, but at paragraph 38 you say that:

"The reference to airway constriction is not the most user-friendly wording. It is also not wholly correct in that it might not be airway obstruction, it might just be chest impingement and they can breathe to an extent but their airways are open."

Can you expand on that at all? Can you help us to understand the difference between an airway constriction and a chest impingement?

A. So airway relates to the lips, to the back of the mouth, the nose, the throat and the voice box, and that would be classed as -- so compression onto those areas would be classed as being airway constriction. For chest

constriction it would be applied to the entire area around the chest, front or back, and it may be partial or it may be complete.

Q. So in your statement when you say it's not wholly accurate -- sorry, not wholly correct, it might not be an airway obstruction that is the risk factor, it might just be chest impingement?

A. Yes.

Q. So the airway is open but there is pressure on the chest?

A. Yes.

Q. But on this list of risk factors we only see reference to airway obstruction, or constriction rather.

Doctor, we have heard evidence from Inspector Young and the Chair has before him a number of statements from officer safety trainers to the effect that the training that was delivered was perhaps wider or broader than what we see set out on paper here and we have heard evidence that officers are trained that restraint is a risk factor for positional asphyxia but I think if we look down this list we don't see restraint referred to as a risk factor?

A. No.

Q. We have heard evidence that officers are trained that the application of weight or force to the upper body is

a risk factor, but again that doesn't seem to be listed in the risk factors in the manual?

A. No.

Q. And similarly we have heard evidence that officers are trained that the longer that a person is in a position that restricts their breathing, the greater the risk?

A. Yes.

Q. But there's no reference to that in the list of risk factors?

A. No.

Q. Okay. Can we move on to the signs and symptoms please. I think it might be -- sorry, it's the same page but maybe the right-hand column. Thank you:

"Officers should recognise the following symptoms and be prepared to administer emergency first aid:

"Body position restricted to prone, face-down.

"Cyanosis (bluish discolouration of the extremities).

"Gurgling/gasping sounds.

"An active subject suddenly changes to passive or loud and violent to quiet and tranquil.

"Panic.

"Verbalising that they cannot breathe."

Would you wish to offer any comment on the signs and symptoms that are listed there?

A. Just that cyanosis is a very difficult medical sign to recognise, even in hospital environments, and it's usually at the very, very end of the restriction cycle and once cyanosis has developed, then the person is at great risk of going into cardiac arrest.

Q. So it's a late sign?

A. A very late sign, yes.

Q. Can you explain what cyanosis is? The list says, "Bluish discolouration of the extremities". What would cause it?

A. So the oxygen is carried round the blood on haemoglobin and cyanosis is where you have a reduced amount of oxygen bound to that haemoglobin.

Q. You say that cyanosis is difficult to identify, even to the trained medical eye?

A. Yes.

Q. Is cyanosis easier or harder to identify in a person of colour?

A. It's harder to identify.

Q. Can we move down the page please. There's a description of the physiology here, thank you:

"When a subject has been involved in a physical and violent struggle, the exertion involved causes the muscles to use oxygen at an increased rate. The process can cause oxygen debt in the muscles and the

physiological response to that is accelerated breathing."

Would you agree with that statement, Doctor?

A. Yes.

Q. "When a subject is restrained, ventilation (the process of getting air into and out of the lungs) can become more difficult, due to the internal organs exerting pressure on the diaphragm. This is particularly evident when a subject is placed in the prone position or pressed against a surface."

Again, would you have any comment to make in relation to that statement?

A. No, I would agree with that.

Q. I wonder if I can take you to another paragraph of your statement, and again we can simply leave this on the screen and I will read it to you but there's a hard copy in front of you if you would find it helpful to look at that, Doctor, and it's paragraph 44:

"I am asked whether being placed in the prone position in and of itself would make it more difficult to breathe. It would, even without pressure being applied to the body. The vast majority of respiratory function comes from your diaphragm moving up and down. The prone position restricts that so you can't use your diaphragm as much as you normally would. Then you will

start to use the other muscles as accessory respiration but they aren't as effective as diaphragmatic breathing. It will be a long process to become unwell lying prone but that's what we have seen in some people who have died and been face down."

So you appear to be saying there that the prone position in and of itself can make breathing more difficult?

A. Yes, that would be particularly worse with obese patients.

Q. Okay. Returning to the manual, we can skip a paragraph and move on to the one that reads:

"The process of restraining often requires the upper body to be held down, sometimes by an officer's own bodyweight. This chain of events may trigger positional asphyxia."

And you say in your statement at paragraph 46 that you agree it's true this series of events can trigger asphyxia. Now, again we have heard from Inspector Young and there are a number of statements before the Chair to the effect that the training given to officers was broader than what we see here in black and white and that officers were in fact trained not to apply weight to the upper torso, that the weight should be put through the shoulder, if necessary, but we don't see

a reference to that advice here, do we?

A. No.

Q. Doctor, had you seen this manual before you were shown it at the time that you gave your statement to a member of the Inquiry team?

A. I don't recall seeing the earlier manual, no.

Q. We have heard that a PowerPoint was also used in training in 2015 and I wonder if we can look at that, it's PS17208, and there are three slides on positional asphyxia. The first is slide 23. It says:

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

"Death can occur rapidly.

"Restraints can increase the risk."

Do you have any comment to make on that content?

A. No, I agree with it, especially that death can occur rapidly as well.

Q. And do we note here that by way of distinction between the PowerPoint and the manual, the PowerPoint refers to a position interfering with inhalation and/or exhalation rather than the reference being to obstruction of the airway?

A. Yes.

Q. If we can move to the next slide please:

"Risk factors~...

"Body position which restricts/blocks airway.

"Alcohol/drug intoxication.

"Inability to escape position.

"Subject is prone/pinned against a surface/slumped forward.

"Obesity.

"Restraint.

"Stress.

"Respiratory muscle fatigue."

Do you have any comment to make on those list factors?

A. No, I would agree with all those.

Q. Is there anything, in your opinion, missing from that list?

A. I can't think of one.

Q. We spoke earlier about chest impingement --

A. Sorry, yes, yes.

Q. -- or application of pressure to the torso, but that doesn't seem to have been included in the list. And again, as we have already discussed, there's evidence before the Chair that there is a relationship between the length of time that a person is in a position that restricts the airway or is prone and the risk of

positional asphyxia which doesn't appear to be mentioned, there's nothing there about the length of time.

A. No.

Q. Can we move on to the next slide please:

"Signs and symptoms.

"Active to passive/loud to quiet.

"Gurgling/gasping sounds.

"Cyanosis.

"Verbals."

Do you have any comment to make on the signs and symptoms that are listed?

A. Just that usually these signs are late on in the process and probably would mean that cardiac arrest is imminent.

Q. Doctor, are there earlier signs and symptoms that a lay person might pick up on?

A. Not really -- well, they may see someone panting, hyperventilating, but there's not really anything to say that person's got positional asphyxia. It's a very slow, insipid process.

Q. I wonder if we can look briefly at the first aid materials from 2015. Let's look at SPELS firstly, although I think the content of the SPELS and the First Aid at Work is very similar, but SPELS is PS12313.

So here we are, "Scottish Police Emergency Life

Support". Can we go to page 15 please.

Sorry, can we scroll down a little. It's page 15 of the PDF. It may not be page 15 of the manual. Is that page 15 of the PDF? I think I must have the wrong reference. I wonder then if we can look at the first aid manual instead. I think the content of the two is the same and the reference for the first aid manual is PS12384. And I understand this is the First Aid at Work manual. If we can maybe look at the first -- the content of the first page. Do we have a date on it? It appears to relate to First Aid at Work and it's July 2014, thank you.

Can we go to what is page 46 of the manual but I think it's 50 on the PDF and if we scroll down a little please, a little bit more. The bottom bullet point there is -- there we are, "Positional asphyxia":

"The death of persons in custody has been attributed to this condition. In otherwise healthy individuals it can occur where an individual is held down or placed in a prone (face down) position. Although instances are comparatively rare risks may be increased where the detainee is obese, drugged or intoxicated."

Would you have any comment to make on that first paragraph, doctor?

A. No, I would agree with that.

Q. The second paragraph reads:

"Most recent medical opinion suggests that it is restraint and the exertion against such restraint that may result in death, rather than the casualty's position. Some doctors put forward the view that the condition may exist exclusively in intoxicated and obese persons, particularly those persons with a 'beer belly'. The term Restraint Associated Death ... may give a more accurate description of this condition."

Do you have any comment to make on that paragraph?

A. I think that's overly simplistic of what the process is. They're right to draw attention to the obese persons, but people that are not obese can suffer from this.

Q. And in relation to the statement that most recent medical opinion suggests that it is the restraint and the exertion against such restraint that may result in death rather than the casualty's position, the Inquiry has heard evidence about the risks of positional asphyxia and I wonder if you have a view as to whether the comment there that we see in the First Aid at Work manual is an appropriate one?

A. I think it's an appropriate one and I'm not familiar with that particular research that has been quoted.

Q. Sorry, did you say appropriate or inappropriate?

A. Appropriate.

Q. You think it's appropriate?
A. Yes.
Q. The statement that:

"... recent medical opinion suggests that it is restraint and the exertion against such restraint that may result in death~..."

Rather than position?

A. No, I don't agree with it.
Q. You don't agree with that?
A. No.

(Pause).

Q. I may come back to that, Doctor, but for now we shall move on from that.

This, I think -- if we scroll down we can confirm that this is the entire chapter on -- yes, positional asphyxia. That's all that the First Aid at Work manual has in relation to positional asphyxia, so there doesn't appear to be anything there about risk factors, or signs and symptoms, or the management of the condition.

I wonder if we can move on to the 2022 materials. Can we look at the current officer or operational safety manual, PS18539, module 4, "Medical implications and mental health", and if we can go to page 3 of the PDF please and look at what current manual says about positional asphyxia:

"Positional asphyxia also known as postural asphyxia, is a form of asphyxia that occurs when a subject's position prevents them from breathing adequately, and may result in respiratory failure, and death."

And you make a comment in your statement, and again we will just keep this on the screen but this is paragraph 66 of your statement, but the language is more user-friendly than the language used in the 2013 manual:

"Asphyxia is not simply someone being stopped from breathing completely. It may also occur because someone isn't able to breathe in sufficient air to meet their body's need of oxygen, something that may happen during a prolonged physical struggle."

If we look at the second paragraph here:

"Positional asphyxia can occur rapidly when the subject is placed in a position that impedes the ability to inhale and exhale breath. It most commonly occurs in persons intoxicated with alcohol or drugs, or to those with reduced levels of consciousness. Being placed in the prone position for an undue period of time, or pressure applied to the back or chest, have been found to be major causes of positional asphyxia in the past."

And again, you say in your statement that you agree with that content and there appears to be a clearer

explanation of positional asphyxia here than there was in the 2013 manual; is that correct?

A. Yes.

Q. If we move on to the next page please where the risk factors are listed:

"Factors making an individual more susceptible to Positional Asphyxia:

"Age.

"Obesity.

"Alcohol and/or drugs.

"Exhaustion/fatigue.

"Respiratory illness.

"Disability (including pre-existing conditions such as epilepsy and asthma).

"Physical position (in car/van footwells, slumped face down).

"Restraint."

And you say in your statement at paragraph 69 that you can't think of anything of significance that's missing from the list?

A. No.

Q. "Signs and symptoms.

"Difficulty breathing, gurgling or rasping sounds.

"Subject verbalises that they cannot breathe.

"Panic.

"Swelling in the face and neck, expansion of veins in the neck.

"Behavioural changes - an active subject suddenly becomes passive, or a loud subject becomes quiet.

"Cyanosis (lips/nail beds/gums are discoloured). This is a late sign and difficult to identify."

Again, we will leave this on the screen but at paragraph 71 of your statement you say:

"I don't think it is appropriate for a lay person to be looking for these because clinically they are subtle signs even for trained medical personnel to identify."

A. Yes.

Q. You mentioned that earlier in relation to the cyanosis.

A. The cyanosis, yes.

Q. Would that apply to all of these different signs or just the cyanosis?

A. I would say the swelling in the neck, expansion of the veins in the neck, that -- that would be difficult for lay people to take note of. The other changes, I would agree that they could be seen.

Q. Can we move on to the next page of the manual please:

"Restraint.

"If a subject is placed in the prone position during restraint, breathing can become more difficult, due to the internal organs putting pressure onto the diaphragm.

If the subject's arms are restrained to the rear, the pectoral muscles can be affected, this can also restrict the ability to breathe."

Would you have any comment in relation to that?

A. No, it seems -- that's accurate.

Q. That's accurate, okay. Moving on to the next paragraph:

"During the process of restraining a subject the officer/staff may be required to use body weight to restrain a subject. This additional pressure to the upper body, in addition to police restraint techniques may restrict the subject's ability to breathe, and subsequently cause the subject to struggle harder in an attempt to breathe. This struggling could be misinterpreted as an act of violence directed towards the officer/staff, who as a natural response might apply additional pressure to the subject in an attempt to restrain them further. Officers/staff should be aware of this cycle of events and the possibility of causing Positional Asphyxia."

And again, do you have any comment to make in relation to that?

A. No, other than it's very difficult for police or lay people, even for medically qualified people, to know whether someone's becoming hypoxic due to positional asphyxia or whether they're just being aggressive and

fighting.

Q. And in relation to this cycle, as it is referred to at the bottom of that paragraph, I think you say in your Inquiry statement that this is crucial information to make officers aware of?

A. Yes.

Q. In your Inquiry statement at paragraph 77 you say that you think this guidance is up-to-date and appropriate?

A. Yes.

Q. Has any of the content been written by you?

A. Not in this, no.

Q. Sorry?

A. No.

MS THOMSON: No.

Before we look at the next document in the training materials, I'm conscious of the time, sir, I wonder if this is a convenient place to break?

LORD BRACADALE: Yes, well, we will take a 15-minute break here.

(2.59 pm)

(Short Break)

(3.15 pm)

LORD BRACADALE: Ms Thomson.

MS THOMSON: Thank you. Can we go back to the first aid manual from 2015 please, that's PS12384, at what is

page 50 of the PDF. If we scroll down please. Thank you. If we stop there.

Doctor, we have looked at this already and I invited your opinion on that second paragraph and I think that I have caused confusion here and we have possibly been at cross-purposes and I want to just try and resolve this, so if we look again at the first sentence in that second paragraph:

"Most recent medical opinion suggests that it is restraint and the exertion against such restraint that may result in death, rather than the casualty's position."

Now, the Inquiry has heard quite extensive evidence during the cause of death hearing from a number of expert witnesses, including two pathologists, a Dr Shearer from Edinburgh and a Dr Nat Carey who is a Home Office pathologist, to the effect that restraint and struggle against restraint can cause death. Their evidence, however, was that position is still an important factor and not one that should be left out of consideration, and I see you nodding your head --

A. (Nods). Yes.

Q. -- would you agree with that?

A. I would, yes.

Q. So to the extent that the way that this paragraph is

worded might suggest to the reader that position is unimportant or irrelevant, I wonder whether it could perhaps have been phrased a little differently?

A. Yes, I agree with that, yes.

Q. You would agree, thank you.

There was one other matter I wanted to clarify with you. Before the break you referred to positional asphyxia as a slow and insipid process and I think that's on page 136 of the transcript. And again, we have heard evidence that a person who has suffered from positional asphyxia can collapse really quite suddenly and without any apparent warning and I just wondered if you could perhaps explain what you mean by it being a slow and insipid process and how that might fit with evidence of sudden collapse?

A. I agree that it can be both slow, or it can be, you know, rapid. In the case of it being rapid I think it would have to be a significant insult to the body to reduce the work of breathing. The slow aspect of it is where, you know, there's just gradual obstruction of the airways, or gradual obstruction of the chest wall movements and then that would be a slow mechanism for positional asphyxia to occur.

Q. Thank you.

We were going to go on to look at the 2022

operational safety training materials. Let's begin with the manual, PS18539. So, "Medical implications and mental health". If we scroll through please as far as page 3 -- sorry, can you give me just a moment please. I think I have lost my place in my own notes, Doctor. Bear with me just a second.

Sorry, it was the PowerPoint we were about to look at, not the manual, before the break, my apologies. So the current first aid PowerPoint is PS18585. So we can see this is operational first aid, version 2, and if we can go to slide 31 please:

"Positional asphyxia.

"Can occur when a person is placed in a position that interferes with inhalation and/or exhalation.

"Risk factors include:

"Physical position and restraint(s).

"Alcohol and/or drugs.

"Age.

"Obesity.

"Exhaustion/fatigue.

"Respiratory illness.

"Disability."

And I think you say in your Inquiry statement that that covers the key risk factors. Again, we don't see mention there of the prone position or the length of

time that a person is in position, or the application of body weight as risk factors and we have yet to hear evidence about the way that officers are trained today.

Moving on to the next slide please:

"Signs and symptoms.

"Body position.

"Gurgling/gasping.

"Behavioural changes.

"Panic.

"Verbalising that they cannot breathe."

And in your statement in relation to body position you say:

"It would be if the person has been restrained in the prone position or if they're curled up in a ball."

A. Yes.

Q. Can you explain -- expand on that perhaps a little?

A. So if they were curled up in a ball, they are impairing their diaphragm's ability to ventilate the lungs and you would remove them the prone position to get the weight of the organs off the diagram and allow it to ventilate the chest again.

Q. Otherwise do you have any comment on the list of signs and symptoms in the PowerPoint?

A. No, I think that covers everything.

Q. In relation to treatment:

"Remove from prone ASAP.

"Treat as a medical emergency.

"Continue to monitor the casualty's condition.

"CPR if indicated."

Again, do you have any comment there?

A. No, I would agree with that. It would be making people aware that CPR may be necessary in these cases.

Q. Let's look now at the current probationer first aid manual which is PS18581, unit 1, lesson 7. We can see this is the probationer training programme, unit 1, lesson 7, and I think we're at page 35 of the PDF, "Positional asphyxia". So you make the observation in your statement, doctor, that this reflects in the material in the corresponding PowerPoint but in greater detail, so let's move through this quickly. If we scroll down a little please, so we can see more of the text on the left:

"Officers/staff should be familiar with the danger of Positional Asphyxia. Positional Asphyxia can occur when a person is placed in a position that interferes with inhalation and/or exhalation, and cannot escape that position, usually when placed on their front. It is most commonly found in persons intoxicated with alcohol and/or drugs, or with a reduced conscious level from head injury. Persons who have been sprayed with

irritant spray are also at an increased risk.

"Death can occur rapidly as a consequence, and there have been cases where Police Officers have been found liable."

Is there any comment that you would wish to make in relation to that?

A. No, I would agree with it.

Q. I think we can move on then to look at training on ABD and again we will begin, Doctor, by looking at the 2015 materials and then we will look at the up-to-date materials, so let's return to the 2013 probationers' manual please, PS10938. We have seen this document before. If we can go to what is page 24 of the manual, but page 30 of the PDF. If we can scroll down a little please:

"Excited delirium ...."

As it was known in 2015, I believe:

"What is excited delirium?

"This is when a subject exhibits violent behaviour in a bizarre and manic way.

"Excited delirium is a rare form of severe mania which may form part of the spectrum of manic-depressive psychosis and chronic schizophrenia."

So firstly if we look at the language used here, "excited delirium", we know that the condition is now

known as ABD. Can I invite your comment on the content of the statement:

"... a rare form of severe mania which may form part of the spectrum of manic-depressive psychosis and chronic schizophrenia."

A. So I would disagree with that. I wouldn't use those terms. Aside from the excited delirium part, a rare form of severe mania, that's incorrect. Mania is one form, but it's not part of excited delirium. Then this, "part of the spectrum of manic depressive psychosis and chronic schizophrenia", the vast, vast majority of cases are due to drugs rather than mental health.

Q. The manual reads:

"It is characterised by constant, purposeless, often violent activity with incoherent or meaningless speech and hallucinations with paranoid delusions."

And I think you comment in your statement that that is accurate?

A. Yes.

Q. "Subjects can be dangerous and may die of acute exhaustive mania. Hyperthermia (overheating and profuse sweating, even in cold weather) is often part of the condition."

Can you comment on the content of that paragraph?

A. So I would remove, "They may die of acute exhaustive

mania", and leave everything else in.

Q. I think you explain in your statement that the medical profession don't use the phrase "acute exhaustive mania"?

A. No.

Q. Why not? Does that mean anything to you, acute exhaustive mania?

A. It's a very, very old term going back to probably 19 -- the early 1900s when there wasn't a classification of illnesses back then and it was used back then to diagnose like bipolar affective disorder.

Q. If we scroll down a little bit please, thank you:

"Why is a subject in an excited delirium state of particular concern?

"Subjects suffering from excited delirium can die suddenly during, or shortly after, a violent struggle. This could occur whilst at hospital or in custody."

Do you have any comment on the content there?

A. It is more likely to occur on-site, on-scene rather than in hospital.

Q. "How is it caused?

"A combination of either drug intoxication, alcohol intoxication or psychiatric illness.

"Cocaine is the most commonly associated drug with this condition, however other drugs have the potential

to induce excited delirium."

Again, would you wish to offer any comment on that?

A. No.

Q. If we scroll back up to the top of the page, right-hand column this time please:

"How do officers identify a subject in a state of excited delirium?

"They will be abnormally strong.

"They will be abnormally tolerant to pain.

"Incapacitant sprays may not work on them.

"Their skin may be hot.

"They may be hallucinating, hiding behind objects, running around or pulling their clothes off.

"They may suddenly become subdued or calm after a bout of extreme violence."

A. I would agree with that.

Q. You would agree with all of that. I wonder if we could move briefly to your statement please. If we look at paragraph 55 of your statement. So you were shown this list. At 55 you say:

"I have been asked to comment on this. I agree with this list of symptoms. In terms of the individuals showing abnormal strength, this is correct. I've seen six police officers trying to hold down a male with this condition and being thrown off by the individual, who

was not a muscular individual at all. Additionally, due to possible paranoia they may feel the police or emergency support staff intend to harm them and consequently they are in a fight for their life."

You continue:

"Police control techniques or the use of plain compliance techniques. The wrists are held with handcuffs where their arms are locked with the hammer lock on or other techniques. You stop moving because it's sore. If you stop moving you will make it better for yourself. However, individuals suffering from ABD often have a reduced sensitivity to pain, so they keep fighting and fighting."

And you explain that "hot to the touch" is a reference to hyperthermia and you suggest that saying "hot to the touch" is more user-friendly effectively to the lay person than hyperthermia.

If we can return to the manual please. Sorry, the manual please. It is, sorry, 10938 and I think we will be on page 30 or perhaps 31 of the manual. There we are. Where we are on the right-hand column, if we could scroll down a little please so we have that heading:

"Actions to reduce risk of death in restrained subject exhibiting excited delirium.

"The subject should be placed onto their side, or

into a kneeling/seated position as soon as possible.

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

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

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

Would you like to comment on that content?

A. No, the only other thing I would put in is to say the definitive treatment is to take to medical -- bring to medical attention, but otherwise everything else is fine.

Q. So there are actions in terms of administering first aid and placing the person onto their side and monitoring them and so on, but there doesn't appear to be any mention there of de-escalation?

A. No.

Q. Nor is there any mention of calling an ambulance?

A. No.

Q. No. Although we see a little further down the page that:

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

Although the manual doesn't appear to offer any guidance as to how a person suffering from ABD should be conveyed to hospital. Would that be fair?

A. Yes.

Q. I wonder if we can look again at the PowerPoint on excited delirium, that's PS17208. It is slides 26 and 27 please. So there are two slides on excited delirium:

"A person exhibits violent behaviour in a bizarre and manic way.

"Constant, purposeless, often violent activity.

"Meaningless speech and hallucinations with paranoid delusions.

"Abnormally strength and pain tolerance.

"CS may not work."

And you note in your Inquiry statement that the body feeling hot to the touch has not been included in that list.

A. No.

Q. Would you have any other observations on that list of signs and symptoms?

A. No, I think I would -- it's just that would be the most important one I would want included.

Q. If we move on to the next slide please, causes of excited delirium:

"Drug and/or alcohol intoxication.

"Psychiatric illness.

"Or a combination of the above.

"Medical emergency.

"Expect a sudden collapse.

"Acute exhaustive mania can be fatal."

Again, would you wish to offer any comment on the content here?

A. I would just want to say that under the causes the vast majority is down to drugs rather than psychiatric illness and the medical emergency bit, again not use "acute exhaustive mania", I would just use "sudden death may occur".

Q. And again in your Inquiry statement -- and I will just read from it if I may so we're not chopping and changing documents -- you say at paragraph 37 of your statement that:

"The slides include symptoms, the fact that it is an emergency and the causes but they don't give advice on how to handle the situation. I'm asked what advice I would expect to see. Back in 2015 the training would simply be to get the person to hospital based on the fact it was a medical emergency."

A. Yes.

Q. Let's look now at the first aid materials. I won't ask you to look at the SPELS material. So far as I can see

there's nothing about excited delirium in those materials, but if we look at the First Aid at Work manual -- this is PS12384 -- so let's just get our bearings here. Is this the First Aid at Work manual? The first aid manual. And I would like to go to page 47, which I think is 51 of the PDF:

"Excited delirium syndrome.

"A delirium is characterised by a severe disturbance in the level of consciousness and a change in mental status over a relatively short period of time.

"Signs:

"Profuse sweating due to hyperthermia.

"... reduced clarity of awareness in their environment.

"The ability to focus, sustain or shift attention is impaired.

"The individual's attention wanders and is easily distracted by other stimuli.

"The individual is almost certainly disorientated and may not know what year it is, where they are, what they are doing and the impact of their behaviour.

"Perceptual disturbances are common and the person may hallucinate."

Would you have any comment to make on the list of signs that are listed there?

A. No, that seems quite comprehensive.

Q. Okay. If we scroll down a little:

"A delirium is the result of a serious and potentially life-threatening medical condition. Potential causes include infection, head trauma, fever, and adverse reactions to medications or overdose of illegal drugs such as cocaine and methamphetamines.

"Any person who is delirious requires prompt medical evaluation and treatment. The delirious person is likely to manifest an acute behavioural disturbance. These individuals can appear normal until they are questioned, challenged or confronted.

"When confronted or frightened these individuals can become oppositional, defiant, angry, paranoid and aggressive. Further confrontation, threats and use of force will almost certainly result in further aggression and even violence. Attempting to restrain and control these individuals can be difficult because they frequently possess unusual strength, pain insensitivity and instinctive resistance to any use of force. As many as five to eight people may be required to restrain one delirious adult."

Would you have any comment to make on the content there?

A. No, I would agree with it.

Q. Okay. Let's scroll down. There's Police Complaints Authority recommendations:

"... recommend the following training for police officers to help them differentiate between intoxication and excited delirium syndrome:

"Learn how to recognise the signs of delirium or the initial symptoms;

"Obtain immediate medical consultation and attention for any person who may suffer from a delirium;

"Do not excite, confront or agitate individuals who are delirious;

"Contain rather than restrain when the individual is not dangerous to self or others;

"Avoid the use of force unless individual is dangerous to self or others;

"Use the lowest level of force necessary as well as a method of restraint that will not cause asphyxiation;

"Be cautious and aware of potential side-effects of medication."

Do you have any comment to make on the advice given by The Police Complaints Authority?

A. No. I'm glad that they draw attention to the fact that you should contain rather than restrain. That's particularly important.

Q. And if we can go to the top of that little passage of

advice please, where they recommend this training to help officers differentiate between intoxication and excited delirium, in your statement at paragraph 104 you question whether it's appropriate for a police officer to try and identify a delirious state or its cause because the medical practitioner may struggle to identify a delirious state.

A. Yes, yes.

Q. And could it in fact be difficult to differentiate between intoxication and delirium?

A. Yes. I don't think it would be expected of a police officer to recognise delirium because medical professionals can sometimes fail to recognise it as well, and the police officers are not trained.

Q. Okay. So is their training, as you understand it, more about identifying red flags --

A. Yes.

Q. -- and seeking medical help?

A. Yes.

Q. Again, we see a reference to obtaining immediate medical consultation and attention, but there doesn't appear to be any guidance on how that looks in practice in terms of whether you convey a person to hospital, call an ambulance~...

A. No, I would agree.

Q. I wonder if we can move on to the current materials. The operational safety training manual from 2022 is PS18539 and page 6 I think relates to ABD, "Acute behavioural disturbance", so we see immediately a change in the language being used there from ED to ABD:

"Just as abnormal brain function can be associated with a stupor or loss of consciousness, it can also cause confusion or agitation. A severe brain agitation is sometimes known as 'excited delirium' or 'agitated delirium' or more commonly to the police as Acute Behavioural Disturbance.

"ABD is described by the Royal College of Emergency Medicine as the 'sudden onset of aggressive and violent behaviour'. It has been described as when a subject exhibits violent behaviour in a bizarre and manic way, rather than being simply violent."

Would you have any comment to make on the content of those paragraphs?

A. No, I'm pleased that they are referring to acute behavioural disturbance now, and I agree with my own College of Emergency Medicine.

Q. If we go a little bit further:

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

the signs indicating ABD, are common to anyone behaving violently."

I think we can note this is quite similar wording to the 2013 manual and you considered that the terminology was out of date --

A. Yes.

Q. -- it dated back to the 1900s. Would you have the same comment to make here?

A. Yes, I wouldn't refer to ABD as a severe mania or on the spectrum of manic depressive psychosis.

Q. Possible causes are listed. We can go through these very quickly:

"Drug intoxication~..."

And there's a reference now to:

"(... new psychoactive substances, 'legal highs').

"Alcohol intoxication.

"Drug and/or alcohol withdrawal states.

"Psychiatric illness.

"Acute brain injury.

"Acute illnesses resulting in brain inflammation, metabolic problems or limited supply of oxygen to the brain.

"... (low blood sugar)."

I think in your Inquiry statement you say this list is a comprehensive list of the possible causes of ABD?

A. Yes.
Q. And you explain too that some of these causes are ones that you can screen for in A&E?
A. Yes.
Q. Was that a reference to the blood gases looking for blood sugar?
A. Yes, that's right.
Q. And you told us about that before lunch. Okay.

Finally, the signs and symptoms. Sorry, I think we will have to scroll up again and it's on the right-hand column of the same page. Thank you:

"Subjects suffering from ABD may present the following signs and symptoms:

"Constant/near constant activity.

"Unexpected physical strength.

"Significantly diminished sense of pain.

"Non-responsive to the presence of authority figures/unable to follow commands.

"Rapid breathing or panting.

"Do not fatigue.

"Apparent ineffectiveness of irritant spray.

"Violent, bizarre or aggressive behaviour, shouting or panicking.

"Sweating, fever, hot to the touch or removing clothes.

"Impaired thinking, disorientation or feelings of paranoia.

"Attracted to/attempt to destroy glass and reflective objects.

"They may be hallucinating, hiding objects, running around.

"Sudden tranquility after a period of frenzied activity~..."

Sorry, if you can scroll down a little bit please.

"... or vice versa."

Do you have any comment on that list?

A. No, it's quite an extensive list.

Q. Do we see near the top of that list, "Non-responsive to the presence of authority figures/unable to follow commands"?

A. Yes.

Q. And I don't think that was in the 2015 materials.

A. No.

Q. That looks to be a new entry.

Moving on to page 7, "Management of persons with ABD":

"It is recognised that controlling a subject suffering from ABD will always be very difficult. Officers/staff may have to place them face down on the ground in order to handcuff them safely ... must

remember the risks of positional asphyxia affecting a subject who has a brain agitation are far greater than that of a normal violent subject.

"Subjects may be very difficult to control, and can continue to struggle beyond the point of exhaustion making them very difficult to stop, whether or not handcuffs are applied. Once handcuffed officers/staff should not try to restrain a subject face down. Subjects should be placed onto their side, or into a sitting, kneeling or standing position as soon as it is safe to do so. They may continue to kick out and the officers/staff may have to consider application of Fastraps.

"Such bizarre, exhaustive and persistent violent resistance is a classification of ABD. The subject must be monitored carefully as they could collapse or suffer cardiac arrest at any time.

"Officers/staff must treat subjects suffering from ABD as a medical emergency "... must be treated in hospital, as a matter of urgency, even if they suddenly calm down before they get there.

"If officers/staff suspect they may be dealing with an ABD subject then the subject must be checked out at hospital as soon as possible. Officers will not be criticised for taking action.

"Subjects suffering from ABD can collapse very suddenly and attempts to resuscitate are often unsuccessful."

Do you have any comment to make on the content here?

A. No, I agree with it all and also as well it's important to emphasise that officers will not be criticised for taking someone to hospital if they suspect ABD.

Q. Earlier in your evidence you said that you don't perhaps get the heads up that an ABD patient is being brought to your emergency department as often as you would like.

A. Mm-hm.

Q. And I wonder whether it would be helpful to include in the guidance a recommendation that if a person is being conveyed to hospital, whether by police or in an ambulance accompanied by police, they might call ahead?

A. Mm-hm, that would be welcome.

Q. If we can scroll up again please and look at the right-hand column "Operational guidance":

"All subjects who struggle, whether handcuffed or not, risk exhaustion. This increases the chances of sudden death from cardiac arrest, positional asphyxia or other medical issues. It can occur anywhere from the locus to the cells. Officers/staff need to be aware of this and ready to deal with any medical issues as an emergency, should the need arise. If required, subjects

may need to be taken to hospital rather than police custody."

Would you take issue with anything in that paragraph, doctor?

A. No.

Q. "Officers/staff must consider the following actions:

"Recognise the situation is a medical emergency. If possible, alert the hospital staff before arrival, to allow appropriate preparation."

So that's my oversight. I see in fact that recommendation has already been incorporated into the guidance:

"Attempts at verbal de-escalation are often unsuccessful.

"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 [ABD] whilst still affording an appropriate level of protection for the subject, officers/staff and the public."

So as far as alerting hospital staff is concerned, you have explained earlier in your evidence why that's helpful from a medical perspective. I wonder whether

that was a recommendation that you had made at any point through the work that you have done with Inspector Young and your clinical governance work, or if it has made its way into the recommendations from another route?

A. I wondered, because I was saying that back in 2015 to HMP custody patients, as well as police, to alert us if they're bringing somebody in who is potentially violent.

Q. Yes. We see it noted at the second bullet point:

"Attempts at verbal de-escalation are often unsuccessful."

And you make the observation in your Inquiry statement, at paragraph 88, that this could be better worded as "... it could be read to suggest that verbal de-escalation is often unsuccessful and so not worth attempting."

A. Mm-hm.

Q. "However, I agree that attempts at de-escalation are often unsuccessful."

A. Yes.

Q. But the evidence you gave this morning is that your practice and indeed the Royal College guidelines are that de-escalation should always be attempted.

A. Yes.

Q. If we move through the document please quickly. I have one more page to look at:

"Restraining subjects with acute behavioural disturbance."

And the guidance states that:

"The aim of any physical restraint is to minimise the ability of the subject to move and injure themselves or others, and at the same time to ensure that the subject has a clear airway and circulation is not obstructed.

"Officers/staff may be required to restrain subjects at scene, either to protect the subject themselves from further injury, and await medical assistance, or to protect the officer/staff and the public from being injured. In either case the following guidance should be followed:

"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.

"Sufficient officers/staff should be present to ensure safe restraint.

"The lead officer/staff should explain to the subject what is happening in a calm fashion."

Sorry, if we can scroll down a wee bit please.

"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. 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.

"Whenever possible during restraint a safety officer should be identified. Their responsibility will be to monitor the health and safety of the subject during restraint."

And in relation to that advice, you say in your Inquiry statement, paragraph 92, "I think that section is actually my wording", and you go on to say that you recommended the inclusion of a safety officer.

A. Yes, that's right.

Q. Why did you do that?

A. We have learned from our own medical training that if you're dealing with an aphasic person you can't do tasks and effectively monitor the patient at the same time, so we have one person who stands back and they're the overall coordinator and their job is to watch the individual who is receiving treatment.

Q. Finally, if we go back to the top of the right-hand column please, this is guidance in the event that a person loses consciousness:

"Call for immediate emergency medical assistance and transfer to hospital.

"Transferring to hospital should, where possible, be carried out by ambulance. If this is not possible then the subject should be transported by police vehicle.

"Where possible, avoid placing the subject in the cell area of a vehicle.

"Remove all methods of restraint if safe to do so.

"Prior to arrival at hospital, contact should be made with the receiving A&E unit with full details of the subject's condition communicated.

"Place the subject in a position that does not impede their breathing ... commence CPR if required, notify a supervisory officer if one is not present and ... a full record of the perception of the subject's condition and their actions should be marked up in a notebook or custody record ..."

Would you have any comment to make on the information in that section?

A. No, I'm happy with that, thank you.

Q. And the reference to "removing all methods of restraint if safe to do so", I don't think that featured in earlier materials?

A. No. The police are often reluctant to remove restraint when they have had control over an individual, but it's

important to emphasise that it is for the safety of the individual.

Q. Finally, let's look at the current first aid materials please. If we can look at PS18581, which is the operational first aid training programme, and I think it's page 39 of the PDF. So if we scroll down please so we have a little more of the text:

"[ABD] is the accepted terminology adopted by the UK Police Forces, the Ambulance Services and the Faculty of Forensic and Legal Medicine ... it comprises a triad of acute delirium, severe agitation or aggression, and autonomic disturbance ... it is usually associated with drug use, or acute substance withdrawal, but can be caused by other medical conditions ... Around 10-20% of cases ... are caused by pure psychiatric disturbance ..."

And "... death occurs in around 10% of presentations."

If we can scroll down a little bit:

"[ABD] is characterised by three factors ..."

Delirium, agitation or aggression and abnormal physiology.

Would you have any comment on the content of this page of the operational first aid manual, doctor?

A. I'm happy with that.

Q. Happy with that. If we scroll a little bit further on please:

"Persons suffering from ABD can die suddenly, or shortly after a violent struggle ... no warning signs to indicate when a person may suffer cardiac arrest. There are a number of possible causes ..."

They include drug intoxication, cocaine being the best known, alcohol intoxication, drug and alcohol withdrawal, psychiatric illness, brain injury, acute illnesses resulting in brain inflammation, metabolic problems or limited supply of oxygen to the brain and low blood sugar. Any comment on that list?

A. No, that's fairly comprehensive.

Q. That's comprehensive?

A. Yes.

Q. Let's look at the signs and symptoms: constant or near constant activity; abnormal strength; abnormal tolerance to pain; irritant sprays may not work; hallucinations, hiding objects, running around, pulling clothes off; non-responsive to presence of authority figures/unable to follow commands; rapid breathing or panting; resistance to fatigue; violent, shouting or panicking; sweating perhaps profusely; skin may be hot to the touch; attracted to destroy glass or reflective objects; may suddenly become subdued or even collapse after a

bout of extreme violence.

Do you have any comment on the list of signs and symptoms?

A. No, happy with that as well.

Q. If we can move through the manual please:

"Officers/staff must treat persons suffering from ABD as a medical emergency."

And then there's a section on management which recognises controlling a person:

"... will always be difficult ... may have to place the person face down on the ground in order to restrain and handcuff them safely. Whilst the risks of positional asphyxia affecting a person who are presenting symptoms of ABD are far greater than for a normal violent person, sudden death as a result of cardiovascular collapse and extreme abnormal physiology is more likely.

"Persons experiencing ABD must be examined at hospital - even if they suddenly calm down ..."

Would you have any comment on the content of that paragraph, doctor?

A. Again, it doesn't say how to get them to the hospital, but I think we are understanding that.

Q. If we scroll down a little bit further:

"Once handcuffed, officers/staff should try not to

hold the person face down.

"Immediately after the person comes under physical control, they should be placed onto their side ... prolonged restraint in the prone position must be avoided.

"Call for immediate emergency medical assistance and transfer to hospital."

And as you said a moment ago, there's nothing there about how the person should be conveyed to hospital:

"Observe the person's condition continually whilst being restrained as cardiac arrest can occur suddenly and develop beyond the point of viable resuscitation within seconds rather than minutes.

"If [they] become unconscious and stop breathing begin CPR ..."

Would you have any comment to make on this list of management points?

A. No, I'm quite happy with those things.

Q. There doesn't appear to be anything in that list about de-escalation.

A. Again, I think we probably should put it in to say try, you know, but the success rate is quite low.

Q. Okay, and there doesn't seem to be a carry over of the advice to contain rather than restrain that we saw in --

A. No.

Q. -- the operational safety training manual.

Thank you for your assistance in going through those materials. We can put those to one side now.

There's one final matter that I would like to ask you about. I said that we might return to your role as a special constable and your most recent refresher for operational safety training was almost a year ago now but can you recall whether it covered positional asphyxia or ABD?

A. Yes, both of those are featured in the PowerPoint presentation.

Q. They feature in the PowerPoint, do they feature in the classroom element, the face-to-face training that follows?

A. I think the trainers may make passing comment to them about ABD, but for positional asphyxia they warn when you're doing the handcuffing or doing the leg restraints that, you know, you mustn't lay on them prone for too long a period.

Q. Thank you. Can you bear with me just a second please.

(Pause).

Doctor, one final thing. As we went through the materials we identified areas where there were perhaps differences between the first aid materials and the operational safety training materials at the same point

in time and we may hear evidence next week that there is going to be a review in the near future. I wonder whether you would see any advantage in there being standardisation across the board so that the same information is being conveyed in operational safety training and in operational first aid, and a consistency in the message that's being given?

A. Yes, they should be aligned, yes.

MS THOMSON: Thank you. That concludes my examination. I have no further questions.

LORD BRACADALE: Are there any rule 9 applications?

Dr Stevenson, thank you very much for coming to give evidence to the Inquiry. I'm very grateful for your time taken to do that. We're about to adjourn for the day and you will be free to go then.

A. Thank you.

LORD BRACADALE: The Inquiry will adjourn.

(4.01 pm)

(The Inquiry adjourned until 10.00 am on Monday, 4 December 2023)

INDEX

DR RICHARD STEVENSON (sworn) 1

Questions from MS THOMSON 1