The Sheku Bayoh Public Inquiry

Witness Statement

Laura Gibson

Taken by [redacted] via MS Teams on 18th August 2023

Witness details and employment history

1. My name is Laura Gibson. My date of birth is 11th May 1975. My contact details are known to the Inquiry.

2. I am currently an acting Inspector, so a temporary Inspector, within the Mental Health and Suicide Prevention Team of Partnerships, Preventions and Community Wellbeing ('PPCW'). I am based in Glenrothes Police Station in Fife. I have 23 years' police service.

3. The PPCW division was formerly known as the 'Safer Communities' division, which I was previously seconded to.

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4. I have been in my current role as acting Inspector since April 2023. I started my training at the Police College in July 2000. Following Police College, I was then based in Edinburgh City Centre at St Leonard's Police Station as a Response Officer within the Lothian and Borders legacy force. I held this position for around 2 years. I then moved to another city centre police stations, including: Howdenhall, Drylaw Police Station, and Leith Police Station. After around 5 years' service, so around 2005, I joined in the Criminal Investigation Department ('CID'), where I worked in the housebreaking teams, general CID and also public protection.

5. In 2007, I applied for a promotion. I got this promotion and was promoted to Police Sergeant. At the same time I went to the Police College as an instructor in probationer training. I remained at the Police College until around February or March 2011. Whilst at the Police College, I was an instructor in the probationer training division for around 2 years. I conducted all elements of the initial probationer training course.

6. I then became Staff Officer to the Director. This was an executive support/administration function supporting the lead officer at the College and included drafting documents, correspondence, organising meetings and general day-to-day business. I didn't continue my training role during this time.

7. I went on maternity leave in late 2011 and returned in spring 2012. I moved back to Lothian and Borders legacy force and was placed on a project at Fettes. I held a role in the E&D department within the Safer Communities team. At this point, discussions were starting to be had about moving towards a national police force, Police Scotland as it is known now.

8. I was offered a secondment to the national Safer Communities department as to support their national work and to look at developing training materials regarding

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mental health and suicide preventions. That position lasted until Police Scotland came into place and then structures changed, and I moved to the Edinburgh Division where I was a sergeant in something called Preventions, Interventions and Partnerships. This was on 31st March 2014 and was based within the Edinburgh division. This again was a Safer Communities community-based role, but this time based locally in Edinburgh. The name of the department changed when the legacy forces migrated to Police Scotland, but it was the same role.

9. As I said I was the mental health lead in the Safer Communities Division in 2012, upon returning from maternity leave. As well as an interest in mental health, I also had experience in training. Prior to joining the police force, I was a teacher and by that point I also had years of experience at the police college. I didn't ever have any significant professional accreditations within the field of mental health. I did, however, gain a number of mental health training qualifications. I suppose what qualified me to train in this area was the exposure that I had in previous roles, such as working with teams at government and local organisations. I had a good network in the mental health field, particularly being based in Edinburgh where a lot of organisations tend to have their headquarters.

10. In May 2014, I came into a role within the actual Safer Communities team. There was no official title to this role. It was supposed to be a 6-month secondment. But these things never happen that way; you're always there a lot longer.

11. The role within Safer Communities was very much focused on looking at delivery of mental health training.

12. I was located within the Edinburgh division at the West End Police Station but later was based in Fife. It was during this posting that I was under Chief Inspector Andy McCann (now retired); Inspector [redacted] (now retired); Sergeant Pam Colvin

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(now retired). When I came into this role, they were already looking at mental health training and reviewing the content that was already being delivered. I was in this role until 13 December 2015. In total, the role lasted 18 months.

13. I became a sergeant within the wellbeing team from December 2015 until March 2020. I was redeployed to the Perth (Tayside) division as a sergeant during COVID, so I spent some time operationally in Perth just for coverage and for any abstractions during the initial COVID period. The wellbeing team was a national team based in the Human Resource function of Police Scotland.

14. I then secured a position within Scottish Government on secondment working on their Suicide Prevention Action Plan. This was towards the end of 2020. This is a partnership between the Scottish Government and Police Scotland with the aim of identifying the role that police officers have to play in mental health and suicide prevention. The Chair of that group at the time was a former police officer, DCC Rose Fitzpatrick. There has always been that connection and that recognition that public sector needed to be involved in that work. I had almost a sponsored role in that team and my role there was really nothing to do with training to be honest. My role was more to do with looking at innovation in digital, about how that could be explored in terms of suicide prevention strategies, but I did everything pretty much other than that.

15. My Scottish Government secondment was due to end in 2023, but I was asked by the division back in March or April of this year if I wanted to return early to an acting position. I was looking to be promoted for a while, so I left my secondment to pursue that position. I was successful in that bid and since April I've been in an acting position as Inspector within the Mental Health and Suicide Prevention Team of PPCW.

Role within Preventions, Interventions and Partnerships Team (formerly known as 'Safer Communities' division)

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16. I am asked to explain what Safer Communities is and why it was brought into existence. I can't explain why it was brought into existence, but I can give my thoughts on why it was necessary. A large part of Safer Communities is realising that there is a whole system approach to dealing with issues and/or events that occur within our community; whether it's crime prevention, whether it's drug addiction, whether it's children and young people issues, equality and diversity. Safer Communities was all about working on both a preventative and a partnership approach. A large part of the Safer Communities work is about recognising the role that police have to play in this.

17. The Scottish Government often play a part in Safer Communities, as do local government, Convention of Scottish Local Authorities ('COSLA'), and local authorities. It was very much a national perspective. We worked in a twofold fashion in the way that we worked with partners; whether they were public health, third sector organisations, charities, initiatives, government, other emergency responders or first responders as well. The reason that we worked in this way was to make sure that the people that we were supporting were receiving a good service or that they were treated in the right way. I suppose we also wanted to ensure that the frontline officers, in particular, were also upskilled, that they had the right tools available to them to be able to perform some of the tasks in the community. So it was very much a community orientated programme.

18. The programme was understanding, particularly as Police Scotland was still in its infancy at that point, that as much as Police Scotland was wanting to say: "Here's what we want to do nationally in terms of mental health." that we had to recognise that the local delivery might look slightly different. That issue still continues even to this day. Even all those years after the introduction of Safer Communities, local delivery is still a challenge for us. We must accept that what we might aspire to nationally doesn't always land quite as well locally. You know, there's that sense of local delivery, understanding your local community. What works in Orkney might not work in Glasgow

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city centre. That's why I think we are quite unique in Scotland with that perspective. Safer Communities hasn't really changed that much in terms of function to be honest.

19. I am asked whether development of policy and training was part of Safer Communities' remit at the time. Yes, however, these were conversations that were being had before I came in. The national Mental Health and Suicide Prevention team, which were Chief Inspector McCann and people I mentioned before, they would have regular meetings with local representatives. These meetings occurred every two months and the venue would always be different. These were in-person meetings. Before I joined the team in 2014, I attended one of those meetings in around late 2013/early 2014, where we would talk about: potential changes in policy; new initiatives which were coming up; best practice that was happening in Edinburgh which we could share with our partners around the table. I cannot confirm an exact date, however, it would have been before I joined Safer Communities on my secondment.

20. There was some mention of training at one of those meetings that had been requested, or had been discussed at a higher level. I made a comment that I thought that it was strange that every year we get SPELS training or emergency lifesaving, but yet we didn't receive any mental health training. Actually, I recall a number of occasions where I've had to speak with someone who was distressed or suicidal, but I'd never had to apply a bandage to someone, that sort of thing. It was a flippant comment, but before you knew it I was asked to join their team. But it wasn't just me that was making comments. This was acknowledged as well and it had even been discussed whilst I was an operational police officer. It was also being discussed in the department before I even joined.

21. These meetings were really valuable because we were able to learn about changes in policy. We were aware of things that were getting developed, such as Standard Operating Procedures ('SOPs'). As Police Scotland was formed, new standardised policies were being developed, and it was recognised that in some areas

it would be beneficial to support these policies with relevant training. I believe that it was identified that this is where the gap was coming from.

22. One of the main tasks of Safer Communities was to generalise and form a consistent approach to the SOPs. So, this would be their Mental Health and Place of Safety SOP, which is still in existence. This was because each legacy force area had their own version of what they were doing, their own approach to how to deal with someone in distress and their own partnership agreements with the health boards and emergency services. Some were really good and some weren't. Our thought process was that if someone was experiencing poor mental health in Edinburgh, then the response that they get should be fairly similar to if they were Dumbarton or something like that. But it was about understanding that there would be local variances with that, but the overall that the response should still be the same.

23. The team's response to the acknowledgement of these differences was to pull together an SOP. I think when they first pooled all of the documents together they must have thought: "Oh my goodness, where do we start?" So as they were working on that and they thought: "To launch that, we need to have some training to be able to say, 'This has been launched.' We need to support that with some training to remind people what their powers are."

24. I have been asked to clarify what I mean by a partnership agreement between police officers and local organisations, charities, GP practices and mental health nurses. There is an understanding that, as much as it should perhaps not be the case, often police officers are the first to respond in many mental health and suicide incidents. As we are quite often the first to respond in these situations, it is about learning how to navigate that pathway to get the person the support that they need. So when I say partnership agreements it is about ensuring that continuity of service from when the police respond, to who deals with the individual afterwards. There is something called a psychiatric emergency plan, so each health board, they're the

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authors of those. There is an acknowledgement that police are involved in some of those processes and, therefore, that local arrangements will engage with the local police division in that area to negotiate how that process works in their area, so psychiatric emergency plans etc.

25. There would be a degree of similarity but there were approaches / protocols which were unique to each health board and/or geographical area – especially in relation to Out of Hours or unscheduled care arrangements.

Role of Police Investigative Review Commissioner ('PIRC')

26. At the same time as Police Scotland was being created, Police Independent Review Commissioner ('PIRC') also came into being. The initial PIRC inquiries were very much focused on high-risk missing people who potentially had mental health or distress circumstances or deaths by suicide etc., where police had involvement with that individual in the run-up to that. Some of the PIRC reviews and recommendations that arose identified that I think officers were saying: "We're not trained in this." That was often what was said, as well as: "We're expected to deal with people in distress, but we've never been trained about how to engage."

27. The lack of mental health first aid training, as opposed to SPELS, regularly came up anecdotally in meetings. There was an acknowledgment there. You know, they did some mental health training, but there was a frustration that police officers were more and more expected to be the first responder in the absence of partners and didn't feel, to take on that role, adequately prepared.

28. Although they didn't feel adequately prepared the officers did an excellent job anyway. They've got fantastic communication skills. Some of our feedback from people with lived experience actually shows that some of the best responses they get are from police officers, but there was frustration that was borne out of the fact that

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we're often called first, or we're often attending first and we're not suitably trained. Actually, officers usually dealt with things really admirably even without that training, but you know, we had to recognise that.

29. So yes, the lack of mental health training came up anecdotally. In terms of actual mental health training, when I was there as an instructor 2007 until 2009, I'm pretty sure what we were taught was fairly minimal. It was our powers under the Mental Health Act. I can't remember much more, but there was nothing really about soft skills. It was more about procedures.

Probationer training

30. I worked within probationer training at the Police College from around 2007 until 2009. We always had our areas which we probably had a background in. So, for example, I had a background in public protection, so often I would cover the public protection inputs for colleagues and usually they would cover my firearms license stuff. I just couldn't get my head around that as much but, no, you were there for the full spectrum, including officer safety training etc.

31. The probationers did most of their training at the Police College at Tulliallan, though some probationer students will spend some time at their local division doing local training usually to do with computer systems, that sort of thing, and understanding some of the local processes that happen. They might do a visit to a mortuary, for example, or that sort of thing and understand the local community aspect of what exists in their division, so that happened. The only other thing that I can remember doing whilst there, which was not probationary training was we sometimes would deliver arrest or detention training to officers from England and Wales who would sometimes operate in Scotland, so those who had cross-border powers, but that was only a couple of occasions and wasn't that frequent.

Mental health input prior to 2014

32. I am asked what training was in place prior to my joining Safer Communities in 2014 in order to develop the standalone training course, Mental Health Distress and Suicide Prevention.

33. Prior to 2014/2015, there was not a standalone, mandatory course on mental health distress and suicide prevention.

34. Officers would have an input at probationer training which would probably focus on their powers under the Mental Health Care and Treatment Scotland Act, Section 297. From memory, it covered things like what is a detention certificate, what a mental health officer is, why you might need to call them, what happens in a private place compared to a public place, an awareness of some of these things and your powers under Mental Health Care and Treatment Act, so the processes. I think probationer training at that point had obviously had an input from Scottish Association for Mental Health ('SAMH') at that time.

35. Nothing would have stopped officers going on courses, either in their own time or sporadically on a voluntary basis, like I did myself. I had an interest in it; saw that there was a Mental Health First Aid ('MHFA') course getting delivered locally; asked for permission to attend and would attend those courses. Other officers might have done that if they perhaps worked in a community role and knew that the local hospital was perhaps delivering training. So those training courses were open to police officers to attend, but they weren't being delivered within Police Scotland.

36. I have been asked whether it was mandatory for officers to attend these mental health awareness and MHFA training sessions back in 2014. No – it was completely voluntary and hugely sporadic across the organisation. There was nothing other than that at the time.

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37. There would be other sections that appeared in probationer training and obviously I had mentioned that I was in public protection for a period of time and, in those roles, in the training you've got to understand the impact of trauma and mental health, and develop soft skills. For example, I was joint interview trained to be able to interview children.

38. There was mental health, distress and trauma, but not in any way that is looked at these days, but those things were definitely covered. It wasn't like we only talk about mental health in one course and it never features anywhere else. You know, when we are talking about missing people, you would talk about mental health but never anything really focused. That's what was delivered, I think. It is interwoven into some components of the probationer training.

39. I am asked whether I believe that had the officers in attendance on 3rd May 2015 had more specific training (soft-skills etc., de-escalation) on dealing with those in a mental health crisis, particularly those affected by drugs and alcohol, that the circumstances of Sheku Bayoh's death would have been different, if not completely avoidable. From what I know of the circumstances (which is very limited) it appears to be a very dynamic situation. Those officers may have developed soft skills either through experience and/or some basic de-escalation techniques from OST or general supporting witnesses and victims. I can't comment if this would have been effective or if that approach would have been warranted in these circumstances.

40. I am asked whether I recognise that there was a lack of specific training on dealing with those experiencing mental health distress, especially those under the influence of drugs/alcohol, prior to the introduction of the standalone course that I drafted and later rolled out in 2016. I think we can agree that the mental health training specifically to those in crisis prior to this was limited.

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Mental Health and Place of Safety SOP (PS10999)

41. I have been referred to the Mental Health and Place of Safety SOP. To my mind, this is only resource that officers had access to that specifically aimed at educating on mental health.

42. An SOP is a resource to which officers can refer to for guidance. I suppose one of the reasons that the training came into place is that often the officers don't have the time or capacity to read these things. You know, some officers will read an SOP if they've had an interest or they perhaps seem to work in an area where mental health incidents are quite prevalent. You know, if you're working alongside one of the mental health hospitals, you might want to be a bit more familiar with your powers and procedures.

43. I think that it was acknowledged that the department were bringing in a new document which was trying to tie in all these local processes that had happened into this new process. There was an acknowledgement that if it was put on the intranet that officers wouldn't read it.

44. I am asked whether there was any way to track whether officers had read SOPs and whether there were any sanctions for officers not having read an SOP. I think it would be difficult to track. There are a number of SOPS, historically some were very lengthy and it would be unfair to expect frontline officers to know them verbatim. They should be used as reference tools.

45. I am referred to page 12 of Mental Health and Place of Safety SOP **(PS10999)**. This page is entitled "Dealing with persons suspected of having a mental health disorder". I am referred to section 4.1 of this document which reads:

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"Mental disorders affect many people in our communities who lead normal lives, either with or without medical intervention. Persons suffering from a mental disorder may display signs of:

- *Agitation*
- *Anxiety*
- *Paranoia*
- *Hallucination*
- *Self harm*
- *Attempting/threatening suicide.*

Assumptions should not be made about an individual's ability to reason, understand or respond coherently, even if further aggravated by alcohol or other substances."

I am asked whether this guidance would extend to someone having a mental health crisis. This possibly could extend to someone having a mental health crisis. I think it's certainly abbreviated, into four or five points, what someone might be experiencing. Whereas the training certainly went into a lot more information about what someone might display if they were in mental health distress.

46. There was a real drive at this point in recognising behaviours and signs of mental illness. There is a link at the bottom of that section. If an officer wanted to get more information then they could click on that link and it would take them to a list of an expansion of those five or six terms. I would have been surprised that they hadn't included that, but it's good to see that that's there.

47. I am asked to review the guidance listed above, in particular the section where it notes that where someone might be exhibiting aggression, agitation, or anxiety, and informs the person reading the document that they might not necessarily be offending. I am also asked to review the section where it states that assumptions should not be

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made about an individual's ability to reason, understand or respond coherently, even if further aggravated by alcohol or other substances.

48. It's strange because the real focal point of the training and even, I suppose, the SOP, or anything that we were trying to achieve in the department was to remove the stigma that those who are in mental health crisis are dangerous. The media do a great job of implying that. But also throughout, that public safety, your own safety and the person's safety is hugely important, but not to prejudge that just because someone is experiencing perhaps strange behaviour that they're automatically dangerous.

49. I am asked where someone did assume, without good reason, that someone exhibiting the signs of a mental health crisis, particularly someone who was under the influence of drugs and alcohol, was dangerous, whether that would be against their training as at 2014/2015. No, it would not be against their training. Operational safety and unknown risk were always covered, but we would also discuss that the reasons for their actions could be varied.

50. I am asked if I am aware of any other important documents, like the above SOP, that people could refer to, to get information on mental health and how to deal with people in distress. I imagine some of the documents referred to in the appendices of the Mental Health and Place of Safety SOP, so adult support and protection I would imagine would have at least mention or reference to poor mental health. Some of the child protection policies etc. The Missing People SOP would probably have something referenced there. At some point, there was a real focus on suicide prevention guidance and, that was created, but I don't know the date that was created. The Custody SOP would be one that would contain mental health guidance.

51. The point has been highlighted that the appendices that I have referred to are simply SOPs. Yes, they are SOPs, however, I'm pretty sure that the organisations would say that police officers and staff should have a knowledge of these SOPs.

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52. I am asked whether there were steps taken to check whether officers were accessing SOPs and whether access could be monitored on the intranet. I am also asked whether regular encouragement was given by senior officers for officers to top up their knowledge. When SOPS were published they would be promoted to officers and staff nationally. I suppose there was an expectation that staff would be familiar or have an awareness of what was covered.

Mental Health Briefing Paper authored by Andy McCann (PS11409)

53. I am referred to a Mental Health Briefing Paper **(PS11409)** authored by my former colleague, Andy McCann. I am asked whether this Briefing Paper was submitted whilst we were in the process of identifying gaps in the training. Yes - there might have been a part of that. I think probably the logistics of the face-to-face training made it difficult. I mean, it was eventually delivered to 17,000 police officers across the organisation at different ranks. Abstractions, logistics and having trainers available would have also been a problem. There was very much a timeframe and a plan of when it had to be delivered. Rolling out training to that many officers, nationally and in a face-to-face environment would be challenging and it required lengthy planning to ensure staff coverage for abstractions.

54. I think I sort of hinted before that, even probably in the initial stages, the course was going to be two days long. Then before we knew it, it was going to be a day long, and then we aimed for a day and then quite quickly we then found that actually it would only be half a day. When we factored in breaks, the allotted training would be pretty much three and a bit hours. The urgency or the momentum may have come from the other training course which was being delivered on the same day. I think there's a recognition, if you've got an officer pulled away for half a day for doing some training, you might as well then deliver something else in the afternoon. Eventually, there was an agreement that the mental health training would be delivered in the morning and that stop and search training would be conducted in the afternoon.

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Prior to introduction of Mental Health Distress and Suicide Prevention course: Mindset e-learning resource

55. MindSET, the North Lanarkshire Mental Health training website was launched on 14th May 2009 at the Edward Lawson Centre, Wishaw. The online training was developed by SAMH, North Lanarkshire Council and NHS Lanarkshire and it contained six sections on mental health: positive mental health, mental health problems, mental health stigma, recovery, suicide prevention and mental health inequalities. The information provided is for people who have no previous training in mental health. It gave users a broad overview of the area of mental health improvement from promoting positive mental health to recovery from mental health problems.

56. One of the first action points on the Briefing Paper was to roll out MindSET, which was an e-learning resource which became immediately available as at September 2014. This was published on the Police Scotland intranet. I even recall there was memos and briefing papers that went out, usually from the head of Safer Communities, saying that this is coming, and it's usually directed towards divisional commanders saying: "There's an expectation that your staff will complete this." I think I'd advise you that we were very acutely aware that we had three hours now of classroom-based focus. There was a real urgency to talk about some of the soft skills which we were still insistent had to be done face-to-face rather than online. We thought we could perhaps do that pre-learning through MindSET and others by doing that online.

57. I am drawn to the date (8th September 2014) on this Briefing Paper and to where it states that the resource was available to use immediately. I am asked whether this meant that officers were given access to this immediately. I think that was just a turn of phrase that they used. I interpret this to mean that it was ready to use in that we

didn't have to develop it. It wasn't distributed to people until 2016. I'm sure at September 2014 we never thought that the eventual roll out date would be into 2016. I think we were trying to sell the point that: "It's there and ready; we can use it whenever. We're not having to wait on it being built or developed." We were trying to sell it as a really good product that was given to us for free.

58. There was a period of time where worked stalled in 2015. We got so far with the development of the mental health training, then work stalled and then there was lots of logistics and planning.

59. We didn't make it available because therein was one of the issues. MindSET was a publicly available resource that I came across in my research because we were thinking that we were going to have to draft something. Actually, we came across this package which was developed by a mental health organisation. We thought: "They've developed it, it ticks everything that we were hoping it would do and you get a certificate at the end. Let's make this available for our officers as a bit of pre learning." This would still be mandatory, they had to do it before going on to do the face-to-face training. So we made contact with the owners of this training product who were, I think, SAMH and a local authority had got money for it, and they agreed that we could use it. The problem was our Moodle online platform, which police officers use to access e-learning, it wasn't compatible with that. We almost had to rebuild it, so that took a bit of time as well. But the content didn't change; the content was exactly the same.

60. The MindSET course was mandatory for those people who wanted to attend the face-to-facee course. This extended to frontline officers and frontline staff, which would be custody, C3 (Contact, Command and Control), that sort of thing. It was made available to everyone else in the organisation should they want to complete it.

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61. I am asked how completion of the mandatory e-learning was monitored and whether there were sanctions for those who didn't complete the mandatory e-learning prior to enrolling on the standalone course. I'm not sure. Senior managers would be tasked with ensuring that staff under their supervision completed all mandatory training. There was an expectation that you couldn't go on to attend the face-to-face element of the course without having completed the online learning, but I'm not sure how strict that was enforced.

Prior to introduction of standalone Mental Health Distress and Suicide Prevention course: Mental Health First Aid

62. I first trained to become a trainer in MHFA in October 2014. Once you complete the course, you immediately become a trainer. There's an expectation for you to start training others quickly. I'd been on the course myself twice as a student already. I first attended as a student in 2012.

63. I took the further step to become a trainer in October 2014. You have to have been on a course recently as a student to then apply to become a trainer. The training course is a week-long, but it was spread over two weeks. There's almost an agreement, or a licence agreement, that you must deliver a minimum of two courses per year.

64. Once I had experienced the course myself, I thought: "I really like this, I'd be a good trainer on this." I then got a place on the training for trainers course in 2014.

65. I delivered two trainings per year in order to keep that qualification as a trainer. I almost always delivered more than that to be honest. My first delivery of the course was external because you had to deliver it with an experienced trainer supervising.

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66. The first time that I delivered a session was Dundee University. After you completed that, then you were free to do it on your own after that. My first course that I led at Police Scotland was in March 2015.

67. This wasn't a mandatory course; it was an elective course. I publicised the course for people to attend. It was set up depending on where I could travel to and have a venue for as well. It was a big commitment though, because it's a two-day training course and that doesn't always fit well with abstractions, so it's a big commitment for a division to say: "We'll allow an officer to go away for two days". Though yes, it was hugely popular and positive. In fact, I couldn't deliver enough of the training, to be honest.

68. I am asked who this training was directed at and who could attend. Yes, very much anyone: staff, police officer, front line, back office. It wasn't a targeted group we were aiming at. Actually, as it progressed over the years I think between 2015 and 2020, I delivered 34 courses within Police Scotland. I also delivered out with Police Scotland to charities etc. and also the Crown Office. I delivered those training courses towards the end because we were doing a wellbeing strategy, with wellbeing champions. That's where my focus changed and probably why there were so many courses, but it was, again, still open to everybody.

69. I should be really careful to say that this is not a police course, it was just something that I delivered and that was accessible to staff and officers within Police Scotland. This is a licensed product and although I delivered it within Police Scotland, it is very much a general public resource.

70. The Mental Health First Aid course which I completed informed some of the training aspects within the Mental Health Crisis and Suicide Prevention training. For example, our approach to asking someone about suicide, some of the good practice in terms of engaging with people, we referred to a couple of slides about health

warnings and stuff like that. So, I would say that it was informed but we were very much told by Health Scotland that we could not use any of their content, because it's licensed. What we did refer to was only minimal, but I would absolutely say it informed it.

71. I am asked whether there would be a record of officers having attended the MHFA course on their SCOPE record. Yes. Officers would have their attendance on this course assigned to their training record on SCOPE.

72. This course was never mandatory.

Background to standalone mental health training for Police Scotland officers

73. I first joined the Safer Communities team as mental health lead in 2014. I would have started training on mental health shortly thereafter, though not immediately I wouldn't have thought. I think there was a lot of scoping that I had to do, understanding what happened elsewhere. I think I discovered quite early on, or we discovered as a team quite early on, that as at 2014, there was no mandatory training that happened. I had to review what happened at police college as well, because that changed from the time that I was an instructor. Since I left as an instructor, and I cannot recall exact dates, but there was a comment made and I think it was included in one of the requests, that our new recruits were actually better trained in mental health than some people who had been in there for a while.

74. I remember the first couple of months would be understanding what existed elsewhere, understanding, perhaps, what the gap was. I remember going to sit in and see what was happening at the college and sort of trying to understand the lay of the land.

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75. I think round about that time I was also trained in MHFA, so became a trainer in MHFA. I'd done the course myself two or three years previously along with ASIST Training, which is Applied Suicide Intervention Skills Training. I'd done both of those courses myself and I recognised the value of those courses. They weren't bespoke to policing but they were better than nothing, which is what we had at that time. There was a lot of really good stuff in there, but they were quite generic. So I understood there was a lot of relevant information in there and other resources that we could probably use.

76. At that point, the real direction of what the training was to cover was understanding and engaging with people, those soft skills; appreciating the distress that someone might be going through; how to engage properly with them; how to support them going forward; and recognising also that we were never going to solve that person's problems to understand why they might be feeling in distress, that sort of thing. But really, the real focus was particularly those who were suicidal, about how to engage with them, how to ask about suicide, for example, that sort of thing, where people felt frightened to do that before.

Development and delivery of Mental Health Distress and Suicide Prevention training course for probationers in 2014

77. I am referred to PS11056. These are PowerPoint slides that I created. This is an abbreviated version of the final product, Mental Health Distress and Suicide Prevention training course for all officers. PS11056 was delivered to probationers.

78. I am asked whether the training for probationers varied from the final Mental Health Distress and Suicide Prevention training course. The training captured in the slides for probationers were an abbreviated version of what was eventually delivered. This was a mandatory delivery and was usually delivered as a lecture to a large audience of probationers.

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79. I am asked when the course was first delivered to probationers. I am further asked to provide an estimate of how many sessions were delivered to probationers prior 3rd May 2015. I delivered this input 13 times between 2nd October 2014 to 22/04/2015. Attendance would have been tracked by the Probationer training admin function. Probationers were often asked to evaluate their training so this would have been captured through the college processes. The input was always well received by those in attendance.

80. Initially it wasn't set up for probationer training, but at the same sort of time, I think there was a memo drafted in August 2013, which you probably are aware of, from probationer training where Scottish Association for Mental Health ('SAMH'), who are a mental health charity in Scotland. They were delivering a two-hour session to probationers at the college, in addition to their basic training. I think this was a scheduled expert presentation and would fall naturally under the basic training of probationer training course.

81. It was almost expert input that was happening, and it was okay, but you could see there was some gaps in what we were looking for. It was delivered by a third sector organisation and sometimes the evaluation following that wasn't always very favourable, as well as it costing Police Scotland money. So I am not naïve to think that if I was involved, then it would save them some money.

82. After that training was delivered, we were asked to give our perspective on what was being delivered and I think, at that point, there was a conversation to say: "Listen, we're working on something which we would hope to roll out as mandatory to all police officers. We have drafted some initial slides as a short PowerPoint just to see how it lands, just to see what the feedback is, if it's meeting the needs, that sort of thing and we'd be quite happy to deliver that on occasion." I think I delivered it locally maybe a couple of times to just officers in a group that were volunteered or nominated in key division, which is Fife, I think, though I can't remember exactly.

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83. The first probationer training session in mental health was on the 2nd October 2014. The probationer training that was delivered wasn't the full package. It was considerably shorter than what was delivered as a final product. You can see that from the PowerPoint slides that you will have reviewed.

84. The probationer training sessions in mental health were delivered as follows: 4th November 2014 (two sessions), 2nd December 2014 (two sessions), 11th December 2014 (two sessions), 11th December 2014, 22nd January 2015 and 9th February 2015. Every few weeks I was delivering that course. At the same time as delivering it, I was continuing to develop the training programme.

Development of Mental Health Distress and Suicide Prevention training course for all officers in late 2014 and early 2015

85. I am asked to describe the conception of the Mental Health Distress and Suicide Prevention training course, its format and where it fit into Police Scotland training overall. I am also asked whether it formed part of Officer Safety Training.

86. The first few months of my role within the Safer Communities team were spent doing a bit of background, as well as working with partners as well because we recognised that we weren't the ones with all the answers. We linked up with Health Scotland and their suicide prevention training lead and mental health lead. We worked on the package together. So to answer the question, it did not form part of Officer Safety Training at all at that point. That certainly wasn't the remit that I was to cover. That was to be covered by Officer Safety Training, but we obviously provided guidance and advice to them later on but, no, it was very much a standalone course at that point.

87. I am referred to **PS11079** which is an email from [redacted], which I was copied into. This email is dated 13th November 2014. It states:

"Spoke to [redacted] some time ago about base level mental health training. It'll be rolled out sometime to all Police Scotland staff, including officers and civilian staff."

The email states that the pilot scheme took place on 3rd December 2014 and that I carried out that training. This is training that I designed and delivered on mental health. This pilot scheme session was delivered to Fife Officers.

88. Although the email states that the base level mental health training was rolled out as a pilot scheme on 3rd December 2014, I delivered training to probationers before that date. This was to test how it landed and to get feedback from those in attendance. It wasn't a formal or mandatory session. The email above refers to the full training. The mental health training that I had delivered to probationers prior to that was only 1 hour and 20 minutes. It was only going to include some of what we would hope to cover, whereas the session that we delivered in Fife in December was almost a session where we'd say: "How would that fit?" You know: "So here's a slide we would deliver, and this is what we're going to introduce." And getting their feedback from it really. So it was almost a workshop rather than a training session.

89. I am asked how the pilot scheme was received and how I felt that the officers engaged with the material at the time. If I reflect on the probationer training inputs, it was hugely well received, and I'm not being big headed, but partly probably because of my delivery as well. I talk about my own lived experience with poor mental health, so that was discussed. I think it was, sort of, well received because what had gone before was an input from a charitable organisation which did well, but officers felt that there was something that they could action. They were being upskilled in something, rather than being told by a charity that we need to be more empathetic with people with poor mental health. We were giving them the skills to engage properly, and I think at that point we also reminded them about their National Decision Making Model as well and focused on that a little about what sources of information you have available to you.

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90. In terms of the pilot scheme, I mean it was one session to be honest. It was almost an asking of a favour of somebody that I knew just to sense check that we were going in the right direction. I think we even later on we changed it slightly to include de-escalation which we hadn't included before, and that came from feedback I think. The feedback was gleaned through discussion. The slides or the part of the input which was delivered to probationers didn't change an awful lot to when it was delivered to the qualified officers. It was an introduction to distress, suicide, things you would look out for, behaviour somebody might exhibit, words or approaches you might use to ask somebody about suicide and the National Decision-Making Model ('NDM'). That was fairly consistent. There might have been some things that were incorporated to change one or two bits but, that was fairly static, even in what was eventually delivered as a mandatory product later on in 2016. I would say around September 2016. There might have been statistics, or words, or an example of a phrase you might use or something, but there was nothing significant changed at that because it landed well. It was the soft skills they were looking for really.

Content of the Mental Health Distress and Suicide Prevention training

91. There was a real recognition that what was going to be delivered in the face-to-face classroom-based training was going to be those situations where someone is in need of assistance in some way. For example, the SOP, or the Mental Health and Place of Safety SOP, sort of differentiates very clearly that people exist day-on-day experiencing poor mental health, but they don't necessarily reach that crisis point or a crisis point which warrants police attendance. It was very much on those who were in a level of distress which would warrant police attendance.

92. One of the big challenges for us was that the MHFA goes into detail about certain conditions. We didn't have the capacity in the time that we had to be able to do that within the mental health training. We actually felt very strongly that, in any engagement we have with someone who's in crisis or distress, it didn't matter whether

they were experiencing bipolar or psychosis or schizophrenia or anything like that. The important thing was that we understood: that the person needed help; we recognised the signs that someone needed help; and how to engage with them and very much that it's the sort of sticking plaster really until the person can get the appropriate support that they needed. That was the sort of main thrust of it. It wasn't to make the person or individual an expert in mental health. It was that point that police officers are often called, so it's how to support to engage better with someone who might be in that position.

93. It also covered topics, such as: how to support someone before they're then referred on to say a medical practitioner. On occasion, for example, you may have to de-escalate; you may have to negotiate what happens with a person; you also have to have an awareness of what options were thereafter available to someone or to a police officer to support that individual.

94. I have been asked to explain what the ALERT (ASK the person what's troubling them; ASK if they are thinking about suicide; LISTEN actively, non-judgementally and show you care; ENCOURAGE them to get help and support them to do so; REASSURE and give information; TAKE all signs of distress seriously; TAKE action) acronym is and whether it applies to a mental health crisis or where someone is threatening to commit suicide, or whether it can be used for both. We couldn't use the ALGEE (APPROACH, assess for risk of suicide or harm; LISTEN nonjudgmentally; GIVE reassurance and information; ENCOURAGE appropriate professional help; ENCOURAGE self-help and other support strategies) acronym because that is a license, copyrighted acronym from Mental Health First Aid, but ALERT is the one that is used by Health Scotland. I think the ALERT acronym is mainly used for suicide prevention, however, we thought it fitted for crisis or for suicide prevention.

95. The content of the course was to reinforce the message that the purpose of this training was to engage with people who were at risk of harming themselves. People

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who were in a crisis point. I suppose it was probably more suicide prevention we were aiming at rather than crisis, but a lot of people that we engage with who are intent on harming themselves or others might not use the word 'suicide'. It was almost to catch that as well.

96. The main thrust of the work was about engagement. It was about teaching those soft skills and that supportive measure.

97. I'm not an expert and I wouldn't ever describe myself as an expert in mental health and suicide prevention. I am probably more informed than some people, especially in our organisation, so I would put myself there but even at that point, I wasn't aware of Acute Behavioural Disturbance or excited delirium.

98. I am asked about the conditions that weren't covered within the definition of a mental health crisis. There were some conditions that were not covered at the time. Acute Behavioural Disturbance (formerly referred to as 'excited delirium') was not something that was mentioned within the definition of a mental health crisis. It wasn't something that was familiar to us, or talked about at that point. It is probably something that has come up more since the case I am giving a statement in relation to.

99. I am told that a lot of indicators of Acute Behavioural Disturbance would present quite similarly to someone having a mental health crisis. From what I know about ABD, I would agree with that statement. I suppose going back to a decision I made at the time of delivering the training not to go down the route of talking about what depression was, actually, in the moment, that's not important. What's important is to recognise that someone is in distress of some sort and that the person needs help. So, yes, some of the signs and symptoms mentioned within the training that I developed and delivered would be absolutely similar. Did I know that at that time? No, I didn't.

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100. Following what happened in the present case, officers are certainly more informed about that now. Even on reflection from my own experience of going through Officer Safety Training as a student, and even up until that point, mental health and being in mental health distress were used in scenarios. It wasn't something that wasn't touched on at all. Those were scenarios where I performed quite well.

101. I am asked to explain was the SCRO is. The 'SCRO' stands for Scottish Criminal Records Office. Those are sort of systems that if we are able to provide someone's name and date of birth, warning may come up such as 'mental', 'ailment', 'drugs', 'escaper', 'violent', that sort of thing. For example, if a check was done on an individual, if you knew their name at that point, you might be given that warning from your call handler that they have these warning markers attached to them. It would help to inform the officers of the risk level. If they disclosed who they were and their date of birth, then that would assist with the search of the database. It's not a flow chart. These are just points which might inform at various points. It might be either on this occasion, or another occasion, someone had phoned in and said: "My husband who is John Black, born such and such, has left the house in a rage and has gone missing. I don't know where he is." A good call handler who would receive that would check that person and, as they're dispatching officers to the call, would say: "We've done a quick check on PNC or SCRO". Even myself as an officer I'd say, "Can you check the PNC and SCRO for me?". We'd say: "Yes, there's bail conditions for that individual. They're not allowed to approach a particular person", or whatever, or "they've got a warning marker and the warning markers are 'ailment' or 'mental' or 'drug user'" that sort of thing. So it's more about the risk to the officers.

102. I am asked to clarify what the above noted terms mean. When I use the term 'ailment' it would not necessarily mean a mental illness. It could be any ailment. When I use the term 'mental' that refers to a mental illness or disorder.

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103. I am asked whether someone who was previously shown signs of mental health distress, or had a mental health crisis, and latterly became known to police, would be tagged with an SCRO marker. It could be, if it had been previously disclosed to officers at a previous incident and the officers thought it was worthy of noting as a warning marker.

104. Then what happens is markers are put on that individual following information from an officer who's previously dealt with that individual. So if that person has never been involved with the police before or even has, but then perhaps displayed or disclosed that they've suffered from paranoid schizophrenia, that sort of thing, then that officer receiving that information would submit a form to have that marker attached to that person's name.

105. This database is purely for police use. It would never be for partner organisations that would contribute to that. It is not similar to the Vulnerable Persons Database. Certainly my understanding of it is just to make us aware of potential risks. Bail conditions and things can come up against a person's name as well, or wanted markers could also come up. It's just another marker that we would flag.

106. Sometimes tags such as 'violent' can come up as well and also 'escaper' can come up. So if they've tried to escape from police custody, we would be aware of that potential risk. In terms of drugs, they may have concealed drugs previously. Again, if you are going to search an individual, it's handy to know whether there is a risk of needle stick injuries. Again, it is a warning for police. When I say 'violent' it can just mean generally the term 'violent'.

107. I am asked to clarify what I mean by violent and whether, in order to be tagged as violent, the individual has to have committed a violent offence or whether the tagging system is more arbitrary than this. I don't feel I have the knowledge or background to explain that part. I think it could be both. The police would have likely

witnessed the violence. In other words, the individual had been violent with officers during an interaction.

108. I am asked whether ABD (formerly referred to as 'excited delirium') or drug induced psychosis were ever covered when the training was first rolled out to probationers at the time. In the course of the slides that I created, drugs and alcohol as contributors were discussed. Drug induced psychosis was mentioned to people undergoing the training that I provided, but not in any sort of great detail. There may have been occasions where it was mentioned by a student as a point of interest, but it certainly was covered as a contributing factor. Certainly, in MHFA, they go into a bit more depth about drugs and alcohol as being either contributory factors etc. or risk factors, but not drug-induced psychosis and Acute Behavioural Disturbance were not included in this.

External organisations as moderators and supply of material

109. I am referred to **PS12166.** This is an email from James Young to me dated 26th January 2016. My former colleague, Pam Colvin, is copied in. Pam Colvin was the person responsible for drafting the Mental Health and Place of Safety SOP referred to above. She also drafted the suicide prevention guidance, at which point she was a sergeant in the team at the time.

110. This email shows me contacting James Young regarding the mental health section within the OST handbook. I provide a list of people that I would ordinarily contact when drafting mental health guidance.

111. I am asked whether these are the sort of people that I would defer to when creating my own training and guidance. Yes, absolutely. There were external partners. I worked really closely with NHS Health Scotland. They were the ones who sort of quality assured the content of my training and guidance. I deferred to the Mental

Welfare Commission because of their role in making sure that processes and legislation is adhered to from all sides. I deferred to charitable organisations. We also invited SAMH, Breathing Space and Samaritans along to view the training as well, so they viewed that training.

112. In fact, I think there was one where the charities came to one of the pilot deliveries of my own training that I developed back in 2014/2015.

113. [redacted] (training lead at Health Scotland) was involved in helping with the training for trainers. On one of the occasions, I only, sort of, delivered the training for trainers because I'd moved on to a new role by then, so there's an agreement that I would deliver the training for trainers but not anything else. I did deliver one session where Michael Matherson MSP, and others from the Scottish Government, but also Samaritans and another couple of organisations, attended one of the deliveries at some point but not during the pilot phase. That was when the phase was ongoing and, again, they were impressed with what they saw.

114. I am asked whether the people and organisations that I consulted with on the training resources were invited to give feedback and comments. Yes, it would have taken place as part of the quality assurance. There was a bit of a gap between probably 2015 and 2016 when it was eventually rolled out. I can't remember why the momentum of the delivery stalled for a bit. It sounds really random, but I think there might have been a terrorist incident. Therefore, the focus of Police Scotland and other organisations became terrorism and anything else that was on the back burner, sort of thing. I think that it was something like that. I remember commenting on it at the time, because things stalled for a while. That's why it didn't gather pace again till later in 2016.

115. Throughout the process of developing the mental health guidance I remember taking best practice from some of these organisations. We gathered guidance from

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partners, not only for the Mental Health Distress and Suicide Prevention training, but generally guidance form partners informed a lot of the work carried out, including SOPs and training. I remember taking best practice from Samaritans, SAMH, Health Scotland, Mental Welfare Commission. They had vested interest actually because the training composed of three parts: there was face-to-face delivery, but there was also two e-learning products. Because of the time that was allowed for the classroom delivery, we need to make sure that those who attended the training had a background understanding or knowledge before they came to the session.

116. We consulted throughout the process of delivering the training, but also before the delivery of the mandatory training we had an equality impact assessment. There was a consultation done at that point too, but we also quality assured the product with Health Scotland as well.

Eventual roll out of Mental Health Crisis and Suicide Prevention course

117. The course was eventually rolled out in September 2016. I was not included in the delivery of this. By that point, I had moved onto a different department.

118. There were two e-learning sessions that students had to complete online before they came to the in-person session. One was a general introduction to mental health and suicide prevention which we got from a partner organisation. The second was on our legislative procedures and there were some scenarios based in that. Mental Welfare Commission were really, I think, quite keen on that because they had something called 'Place of Safety' forms when someone is detained under the Mental Health Act. This is where you need to notify them. We needed to reinvigorate that section because we need to remind officers of their obligation to do this under the Mental Health Act.

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119. In summary, you had to complete two e-learning sessions prior to attending the course and the in-person training in order to be able to say that you had completed the Mental Health Distress and Suicide Prevention training.

120. As well as the theoretical training, there was a strong practical element to the course. Some of the practical elements actually came with the legislative e-learning as well because we took a slightly new approach. We've got the Moodle platform and, for a long time, it was very much information questions. Our new approach was almost to do scenario-based questions in order to test officers' knowledge of the legislation through a progressive scenario. That worked quite well. We thought that case studies would be useful.

121. The purpose of those case studies was to work through the NDM, and I think, from memory, at the end of each of the case studies, there was three or four questions that, having worked through the NDM, you should be able to answer at the end. It was really a discussion activity with feedback. It was up to the instructor, depending on the engagement he got from the group or how they wanted to deliver it, whether a group would take a different scenario, or they would all work on the same scenario and then feedback. So that's what that was used for. It was also used as a bit of an assessment, actually, if I remember from my training. You've got to do almost like a training synopsis about why you're doing the training, and I think it was used to assess that officers understood and could apply the decision model to that sort of scenario.

122. From memory, at that time, none of them were based on ABD or psychosis or anything like that.

123. Although there were physical scenarios which the officers had to work through, the course did not explicitly deal with the physical restraint of someone going through a mental health crisis. The course very much centered on the communication skills needed for dealing with an individual having a mental health crisis. I suppose two

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points to note here. Certainly in the trainer's notes and, it wasn't a script, but they were told to inform the officers that if it's a set of circumstances where someone's safety is in danger, then nothing precludes the use of our operational safety tactics, first and foremost. It's acknowledged in the training documents that that takes precedence, as does the health and safety of the individual or others around. That's acknowledged. This course was very much focused on the soft skills. I do, as I say, recall scenarios when I undertook my own operational safety training, where we had a potentially violent offender who was suspected of having poor mental health, or they were clearly in a mental health crisis, and the operational tactics that were required. I suppose, reflecting on that, we were quite content that that was already getting covered. Our focus was very much only on the soft skills and the engagement, which is actually what people mostly experienced.

124. I am asked whether the training covered what to do after encountering someone who was having a mental health crisis. I think we talked about what the sort of next steps as they came up in the NDM. I suppose in terms of your options, your contingencies were within the NDM and they were to take action and review what happened, what we did at that point was discuss what were our options thereafter. Once that person has been either in control, we need to focus the needs of the individual as well as the safety of other people. Medical attention takes precedence over mental health. That is in the NDM, so we talk about that. You have to ask the question: has the crime or offence taken place? Because that will determine what route you take. At that point, that's when I remember hearing from people who were delivering the course, the frustrations would come because those routes weren't always open to police officers. If the scenario was, this is just low-level mental health concerns, we would take a different route. So more so in the options and contingencies of next steps, we would talk about what were available, and that's specified in the NDM, and we would talk that through.

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125. I am asked whether, according to the training, where there was a high-level mental health concern and there was a potential for a crime to be committed, medical attention would take precedence. Yes, this is absolutely the case. Custody will want someone who's been in that scenario to be checked, first and foremost. I don't think we were prescriptive in saying: "This is the route you must take", because the route that you must take could be huge and varied. We did talk about what were the options, what's available in your area, who are the referral agencies, know your routes, that sort of thing, know your pathways to support. However, it was very much the message that medical attention takes precedence over everything else.

126. I am asked whether the training covered specific de-escalation techniques that should be used where an individual is suffering a mental health crisis. Yes. It very much focused on communication. We did do internal engagement with our negotiator cadre or team, at the time. We worked with them and now at that point what had been planned for a day's mandatory training had then been reduced to three hours. There was no way that we could go into any great depth about the de-escalation techniques that our crisis negotiators go through. I mean, they go on two or three-week courses to learn about this stuff.

127. What we didn't want to do, in the time that we had available, was to confuse officers by introducing a new technique and trying to rush through it. What we did do is for a number of the situations, a crisis negotiator may come out, whether it's for a siege situation, a violent individual refusing to sort of desist or locking themselves away and refusing to come out or someone standing on the edge of a bridge. We did explain de-escalation, or the stairway that's introduced which we just sort of nod to. It's almost to confirm that the initial engagement rapport building is hugely beneficial because, if a crisis negotiator does come in, you've almost laid the foundations.

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You've been that first or second step. The officers were informed that they are part of that bigger picture and how important it is to do that part.

128. I referred to paragraph 66 of Inspector Young's statement (SBPI-00153) which states:

""My opinion of OST training back in 2014/2015 was it focused heavily on gaining control and gaining compliance. I don't know the circumstances of this incident at all because I've never been sighted on it. However, it wouldn't surprise me, based on the training ethos back then, if officers moved forward to try and establish control and compliance, because that was very much, in my experience, what the training ethos was then."

It is highlighted to me that this differs from the emphasis placed on de-escalation within my own training that I created in 2014. I am asked what my thoughts are on this statement and whether I feel the contents of the training may have conflicted with one another. I've made it very clear that the training I created was about engaging with people who were in mental health crisis and/or suicidal and to deliver a compassionate response. There is very little in the training which relates to violent individuals or in situations where operational safety is the preferred option. This might be seen as an oversight but wasn't what was asked for at the time.

129. Additionally, the OST training in 2014/2015 reflected by Inspector Young in his statement focused heavily on control and gaining compliance and which was in place prior to the incident. The national roll out of the mental health training I developed wasn't delivered until late 2016/2017 after the incident and after the training in 2014/2015 spoken to by Inspector Young. Therefore, there was no opportunity for the training to conflict at this stage. Even in the initial sessions delivered to probationers the focus was about those in crisis/suicidal. De-escalation wasn't included in those

slides/sessions although a compassionate response was. However, I strongly believe that this was not in conflict in what was taught in OST at the time.

130. Inspector Young states that following review and following the incident date notable changes were made to OST in terms of approach, and in my opinion this shift would complement the approach we then delivered in our training. However, I must emphasise again the training in OST is different to what the mental health training was aiming to deliver. Both focus on different approaches for different scenarios and the two shouldn't be confused.

131. I am asked whether the training that I drafted covered how a violent person could present. Yes, I actually don't think I went into great detail about what being violent entailed. What we did say is: understand things like where's the person located, what about the bystanders, assess threat and risk. Is there a history of offending? Is there deterioration in the person's mental health? Any history of substance misuse, that sort of stuff? Any factors known to increase the risk that the person may pose? I do recall, in the notes, referencing that if safety is paramount and, as much as this approach is useful, you will engage with officer safety techniques if safety is at risk. That takes precedence.

132. I am referred to the word 'agitation' which is referenced in the slides I created for training officers. I am asked whether agitation is described on a spectrum and whether the differing presentations of an agitated individual were discussed with the officers. I cannot confirm whether it is something that I discussed with officers at the time. However, I think if I was to describe agitation in a training course today – and even reflecting on what was delivered back then, I'm far more knowledgeable and informed than even what I was back then – I would describe any of the symptoms, the behaviours that anyone displays, whether it's sadness, whether it's anger, frustration, agitation, as all existing on a spectrum. Agitation could be clenched fists to nervous tics, shuffling, muttering to yourself – these symptoms can all be agitation. We all

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experience agitation. We've all got our own wee foibles or behaviours that we do when we're agitated. Mine tends to be drumming my foot or my pencil, that sort of thing. To the extreme of lashing out and directing violence or aggression for other people, so yes, I would describe it as on a spectrum.

133. May I have described it like that in the training? I may have. I don't recall. Certainly, there's nothing specific to say, "Describe those", but from when I do deliver training, and I suppose I'm reflecting on recent experience. I always describe things as on a spectrum. People tend to understand that a bit more. It's to make it more familiar to themselves that we're all at risk of poor mental health or mental health crisis, and it's to make it more familiar with them that they could also be that person at some point. So that's why I always describe it as a spectrum from very minor to significant.

134. This is something that I do in my training practice now all the time. That's almost accepted that that's how we describe it. In fact, when we sort of talk about Autism or Asperger's, we often say that it's on a spectrum. Actually there'll be a number of people, a large percentage of the general population who will be on that very bottom end of that spectrum and have no idea. They're almost described as being a little bit eccentric in their methods, or a bit OCD or that sort of stuff, or a bit particular but, actually they're possibly on the spectrum somewhere.

135. I am asked how completion of e-learning modules was monitored and whether there would be sanctions for non-completion, or whether it was simply the case that the officers undertaking the training would not receive a certificate for completion of the course. Completion of e-learning would have been monitored and updated on an officers training record on SCOPE. I'm not sure about sanctions for non-completion.

136. I am asked what steps were taken, if any, to measure the effectiveness of the training after its eventual roll out. Evaluation of the training was conducted by the Quality Assurance Unit at the Police College but I wasn't involved in that and so can't

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comment. On occasion trainers would get in touch with queries raised during training and we would try and address those by providing guidance and sharing practice to the trainers.

National Decision Making Model for Mental Health Incident (PS12149)

137. I am referred to the NDM for Mental Health Incidents **(PS12149).** The NDM isn't new. The basic context of the NDM is it's existed in policing for years and years. I remember being taught it as a probationer myself. It's something that's widely recognised, whether it's in organisations in England and Wales, and I think internationally actually, but there might be slight changes to it. So the purpose of the decision model is to provide a bit of a framework why someone has taken a specific decision and to almost inform the rationale why they've taken certain decisions.

138. I remember being in the team alongside the others that I've previously described where it was almost a bit of a lightbulb moment. What we were probably asking people to think about when they were trying to think of what to do next and how to inform their next steps was very much based on the decision model.

139. I don't think it changed hugely over the piece. It got really, really favourable feedback. It made sense to officers. Officers like a model or a flowchart to follow to inform and justify their decision-making, because they know it will be scrutinised the next day. So, yes, they liked to be able to say that they followed these steps and here's the reason why. The likelihood is, in everyday practice, they do it anyway, but they liked something there to refer to. It was very well received and it actually fitted what we were hoping to achieve quite nicely with what we put in. It probably does need reviews because things have probably changed that we need to think if it's still relevant now.

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140. The NDM that we used was one that was recognised globally, but we have adapted it for used by Police Scotland in a mental health incident. When we were developing it we asked questions, such as: "How could we apply it to a mental health incident? What would we expect officers to consider when they're gathering information?" Then we would just populate considerations in each of the fields.

141. I recall the generic NDM being taught as early as 2003, but not the NDM which was tailored to mental health incidents. This specific NDM was brought in 2014. At the time when it was introduced it was simply an appendix in the Mental Health and Place of Safety SOP. It was by no means mandatory for someone to review this. It was more a point of reference. Obviously, it was then spoken about and referred to in the training delivery but, also I think it was used after I'd left that piece of work anyway. I do recall that was used in leadership training for situations, because I remember seeing it getting handed out to front-line supervisors to be used as an aide-mémoire. I think at one stage they may have printed aide-memoirs with the decision model on them to give to officers, but I wasn't in the department at that point.

142. I am asked whether the knowledge of the NDM was assessed and how officers' knowledge was gauged as at 2015. We used the NMD applied to mental health incidents in the training created and officers were asked to use it in training by applying it to case studies. The basic NDM process is something which is taught but I'm not sure how, when or how it is assessed.

Role as a trainer

143. Following the eventual roll out of the Mental Health Crisis and Suicide Prevention Course, I moved on. I'd started in a new role, but there had been an agreement that I would deliver the Training for Trainers courses, which were maybe about six of them to upskill all the trainers. The training I delivered was specifically for

the roll out of the training that I developed. That was quite an intensive two-and-a-half-day course that we delivered and that I occasionally delivered too. The understanding was that once we'd delivered that training to all frontline officers, at that point as a mandatory thing. It was heralded as a significant piece of work because no other organisation had done that, even in England and Wales, we were the first to do it, etc. It was then that the product, I think, or the learning that had happened, was to be used or developed into the probationer training programme so that probationers would then receive the same level of training that all the other staff had received. What happened with those negotiations? I have no idea because I wasn't involved at that stage; I'd moved on.

144. The training that I delivered after that point and the training that I deliver now was slightly different, in that when I was working with well-being, it was very much about upskilling supervisors and managers about how to look after their staff, well-being needs, that sort of thing. Also, I continued to deliver MHFA. As I mentioned, we did a sort of well-being champions programme as part of our well-being effort and I delivered for every well-being champion. They all attended the MHFA training, so I delivered that all. Nowadays, the role that I have now – especially as I'm in the acting rank – is far less in terms of instructing. Though, I still do it on occasion.

145. I am asked whether I still deliver training of any kind and if I have any involvement at all in the development of mental health training. I still deliver MHFA training. I will occasionally deliver mental health awareness presentations when asked.

Inclusion of Mental Health Crisis and Suicide Prevention in Officer Safety Training

146. I am referred to an email to James Young dated 26th January 2016. In this email I am sending on material, requested by James Young, which is to be included in the

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Officer Safety Training manual. I believe James Young had already made an attempt at drafting what he was looking to include. He then came to us and we provided further guidance. I also made suggestions of who should be consulted in relation to the material. I am not aware of when Mental Health Crisis and Suicide Prevention was included in the Officer Safety Training manual.

147. I am not aware of when the material I drafted and sent on to James Young was eventually added to the Officer Safety Training manual. I should say that mental health did feature in Officer Safety Training prior to this. I remember this from my own experience.

148. I am asked to provide more information on the content that was taught prior to the introduction of the standalone course. I am asked whether mental health distress and suicide training formed an individual section, or whether it was interwoven into other sections of Officer Safety Training sections. Often the references to individuals in mental health distress were explored during practical scenarios. I can't comment on how prescriptive this element of the course was.

149. It wasn't until I drafted and rolled out the Mental Health Crisis and Suicide Prevention Course, however, that there was a standalone course which covered mental health.

OST Refresher Checklist, Version November 2020 (PS18579)

150. I am asked whether I know when mental health and suicide prevention training began to feature in the OST Refresher training. I can't comment - sorry. We were only asked to provide some guidance for the manual.

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151. I am referred to the current OST Refresher Checklist **(PS18579)**. I am referred to this checklist, but in particular a section named 'suicide intervention'. I am asked whether I know whether this is where the mental health refresher training would come from. I think that's very much a physical control technique for someone. I think the scenario that's used – and again just from memory and just from my own experience – is perhaps someone in custody trying to strangle themselves and a technique that you can use to dislodge that.

152. I am asked whether I know whether the soft-skills involved in handling an individual in a mental health crisis, or someone who is trying to kill themselves by suicide, feature in the current OST Refresher Training. Yes. I did mine on 12th – 13th July 2023, so it's fairly fresh in my head and it's two days long. The soft skills and the engagement skills I would say are minimal but you've got a finite time to deliver everything, so I get that. It also depends what instructor you've got. You know, some will be a lot more informed of these things. Even as an instructor myself, I know that if I get a topic that I'm particularly excited about, I will go on about it. I do remember some soft skills and engagement getting talked about, but was it anything to the degree of what I delivered? Nothing like that. No, it was minimal.

153. I am asked if I am aware whether the physical handling of something in mental health distress is discussed within the OST Refresher training. I have heard from others that within one of the practical scenarios where they look for some people to do role play, there is a mental health distress scenario. The refresher training, which I've only got experience of recently. Also, on the back of that, there are a couple of videos shown of people who are experiencing ABD or distress related to drink or drugs and that's talked about at length.

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154. The checklist is basically skills that we've demonstrated that we're proficient in that we can perform. That we might not be assessed on. Well, we aren't assessed on how we would engage with that person. It's almost delivered as an awareness of those things. The theory PowerPoint would maybe be within the OST theory and even some of the first aid. Some of the tactical positioning, certainly, is talked about in terms of someone who's in distress or is armed with a knife, for example. So, yes, the OST theory in the tactical positioning might be something that's talked about.

Mental Health Distress and Suicide Prevention training as at 2022/2023

155. I am asked whether the training that I created still exists and whether it has been updated. No – I am not aware of this training still being used.

156. It is something which would benefit officers and I would be keen to revisit providing refresher training in mental health in my current role.

Involvement in investigation since 3rd May 2015

157. I am asked if I have been involved in the investigation since 3rd May 2015. Yes – I was a TRIM assessors for one of the officers involved in the case. TRIM stands for Trauma Incident Management. It's almost like a debrief position.

Media

158. To be honest, I am aware of it. I don't actively follow it. If it's in the news, I suppose because I'm based in Fife and it's involving Fife officers and it's an area that I'm familiar with, I'm probably more aware of it than others, but I don't actively seek it out or anything like that.

159. I don't know the officers involved. Whilst my office is physically based in Fife for my national role, I have never worked operationally in Fife. I've never had that engagement. I'm aware of certain people but I've never worked alongside them.

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Declaration

160. I, Laura Joanne Gibson, do hereby confirm that the information provided in this statement is true and accurate to the best of my knowledge.

Date October 10, 2023 | 11:59 AM BST .....

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