



The Sheku Bayoh Public Inquiry

Witness Statement

Chris Stewart

**Taken by [REDACTED]
on MS Teams
On 23 August 2023**

Witness details

1. My name is Chris Stewart. My year of birth is 1984. My contact details are known to the Inquiry.
2. I'm have 20 years' police service as at 1 September 2023. I am currently a Superintendent with Police Scotland.

Career Summary

3. I was in legacy Central Scotland Police, and up until the point when Police Scotland was formed in 2013, I then became an inspector. Generally most of my service, from constable to inspector, has been within an operational policing environment, so local policing, traditional response policing roles, or community policing roles. Then, on being promoted to chief inspector, I had positions within a corporate role which was estates transformation, so that

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was responsible for rationalising the estate and the closure of empty police premises. I then moved on to a chief inspector role in Criminal Justice Services Division, a support and service delivery role in there, so that was focused on people, conduct, estates, finance, health and safety, etc.

4. After that role as a chief inspector, I then became area commander at Falkirk, which is a local policing role. I did that for 18 months and that is really heavily operationally focused, so day-to-day policing. A lot of this is round about people's performance and conduct and welfare, but really dealing with threat and risk operationally within local communities. I was thereafter temporarily promoted to superintendent in the role I'm in just now and that was in April 2022. I was substantively promoted into the role in July 2022. I've remained in this role since that time. This role is within Operational Support Division. It's within the Specialist Services part, which is a national division that provides national specialist resource to local policing divisions. It ranges from Armed Policing, ARVs, dog unit, Air Support, Dive and Marine, so a range of national specialist roles. My role is the support and service delivery superintendent, so that focuses on people, HR, welfare, estates, health and safety, and there's two other superintendents who deal with the operational aspects of it. The nature of my role generally means that I technically deputise for the chief superintendent when she's off.

5. In my career to date, I haven't had any direct involvement in operational safety training, other than attending the annual OST recertification.

Role as chair of the Use of Force Monitoring Group


6. I became the chair of the use of Force Monitoring Group (UoFMG) in 2022. This took place around the same time as my temporary promotion to my current role. I think it could have been potentially May or June of that year. So the chief superintendent, my divisional commander, [REDACTED], who has since left the organisation to a force down south, he was the chair when I joined the division and he asked me to take it on soon after I joined, so

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it would have been about May or June that I was asked to take on the chair of the group last year.

7. I am not the chair of the group just now, I only chaired two meetings. I believe the terms of reference states that it's every quarter, the group, so I believe one was in June 2022, and then one was in November 2022. At the first group I chaired, I was really trying to find my feet, get an understanding of who all attended, what the purpose of the group was and what type of issues would be brought forward and what type of decisions the group would have to make. Then, at the second meeting, there was discussion starting to be had about, if there was changes being made to the OST programme, for example, by an inspector, David Bradley, who is one of the inspectors responsible for OST just now within Learning, Training and Development. So, those questions started to arise, which posed me to ask the questions about, "Is that the purpose of this group? Is this group intended to make decisions round about changes to OST, whether it's new techniques, removing techniques?" If that was the case, then I was really going to have to go and ask a bit more questions and get a bit more clarity on who was best to then chair the Use of Force Monitoring Group.

8. Officer Safety Training – the governance of it and how it's delivered – sits within Learning, Training and Development, there is a chief inspector and an inspector that oversees that. The full-time instructors that deliver Officer Safety Training come under their line management, and that portfolio – Learning, Training and Development – has a separate assistant chief constable to Operational Support Division. For some reason, and I don't know the origins of it, Use of Force, however, as an entity sits under my Assistant Chief Constable within OSD. Hence, the chair of the Use of Force Monitoring Group historically seems to have come from someone within the OSD environment. So that was the catalyst for me starting to ask some questions within Learning, Training and Development to say, "What is the governance for changes to the OST program, new techniques, introducing

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techniques that have been removed before. Where does it go before it comes to the Use of Force Monitoring Group? Is the Use of Force Monitoring Group the right governance route? If it is the right governance route, then am I the best person to be chairing it?”.

9. There was then conversations over the past couple of months between myself and Chief Inspector [REDACTED] within Learning, Training and Development with regards to submitting a proposal that actually someone from Learning, Training and Development would be best placed to chair the Use of Force Monitoring Group, if the expectation is that it is meant to have scrutiny and oversight of changes to the OST programme, new techniques etc. Within the past maybe six to eight weeks, that chair has transferred to Chief Superintendent Alan Gibson. He is the chief superintendent for Learning, Training and Development, so my view is it's probably the right change, so you've got someone chairing the group who effectively has responsibility for OST, so that's where we're at just now.

10. The purpose of the UoFMG is to *“provide a means to monitor to what extent and how effectively use of force is employed within Police Scotland”*. I have been asked to explain how this is done. My understanding is that at the Use of Force Monitoring Group, people from Analysis and Performance will produce an internal statistical report, which obviously has to have a range of data. It separates it right down into the local policing divisions, I believe, so right down into the 13 as well as at national and east, west, and north command area, so that provides a range of data and statistics on how use of force has been used, so from whether there's been an increase in the use of force form submitted in a particular area, where there's been a decrease, whether it remains quite steady with the five-year average, so that's one aspect. I suppose through that data and stats, that would then allow you to have a bit more of a deeper dive. If there was a particular area where the use of force has increased, why is that? That deeper dive potentially could provide the answers. There could have been a small division and a particular

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one-off violent weekend that was unusual, or there's been a decrease in use of force. Why is that? Are officers under recording? Does there need to be a bit of training? So that's the purpose of that report.

11. As well as the number of use of force forms submitted, it also provides an increase or decrease across the country and statistics on the techniques that are used. So you can see if there an increase in empty hand techniques and a decrease in PAVA discharge, for example. I suppose when you see those differences, that then allows for perhaps a bit of further analysis to be requested or context as to why those changes are taking place. For example, if empty hand techniques were significantly decreasing but baton strikes were increasing, why is that? Is it because officers don't feel confident using the empty hand techniques? Is it generally just because the level of threat that they're facing is increasing and empty hand techniques is not appropriate, if somebody's in possession of a knife? So that's how those stats would be used in terms of monitoring the effectiveness of use of force.

12. The use of force statistics and data are also reviewed at the Your Safety Matters Diamond Group, which is a force-wide group chaired by the DCC for professionalism. Both groups are potentially looking at similar stats and data, with the Your Safety Matters Diamond Group probably taking that more higher-level, strategic overview, but that's purely on, "What is the use of force stats telling us? What do they look like and what can we take from that and what does it mean?," rather than any decisions or discussions round about Officer Safety Training, how is it delivered, is there changes needed, etc.?

13. One of the other purposes of the UoFMG is to "*monitor the overall direction and management of operational safety within Police Scotland*". Again, I have been asked how that is done and by what means. From my time only chairing two of the meetings, the only real data set or statistics that were coming forward was the statistics that I've referred to from Analysis and Performance. So other than that, in my time there was no real discussion or information

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provided in relation to that. Now, whether there was oversight of that within Learning, Training and Development, potentially from Inspector David Bradley, I don't know. I don't think I can really comment on that. That's probably one of the reasons why I started to identify, the chair is best placed with somebody in a more suitable role because of the stats aspect. As a superintendent in Police Scotland, you could look at the stats and you could say, as I've alluded to, baton strikes are increasing, empty handed strikes are decreasing, for example. You could do that. What does that mean? Speak to the experts, speak to Analysis and Performance people, but beyond that, I felt that the effective management of use of force or the OST training I wasn't best placed to make decisions on or scrutinise, which is obviously why I highlighted that a change of chair would be more appropriate.

14. I have been asked if I am aware of the decisions making in relation to how the use of force data is published externally. When I came into post in this role in April 2022, it was a couple of months after. I can't remember the exact date, [REDACTED] from Analysis and Performance, pulled these reports together, got in touch to say that a decision made year before that Police Scotland would start producing external use of force data. That this had all been approved through the Senior Leadership Board (SLB) in 2021. The type of stats and the format of the report was all approved, and she explained that we now required to get some of these reports published. There was an HMICS inspection that prompted this and we had got the necessary approval, but it had not been published as yet. If my recollection is right, I think [REDACTED] just pulls the report together, so she's not in a position to actually make the decision to publish each report on a report-by-report basis once they're pulled together. I think she was just really finding it difficult getting someone to say to her, "Right, the report can be published."

15. This was maybe May or June 2022, so once I'd confirmed that it was a decision by SLB that actually they need to be published because that's a decision that the force executive have made and there's an expectation from

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HMICS who I believe gave that recommendation, I said to her (I think I had just recently taken over the chair of the UoFMG), "If you send them to me". I think there was a bit of a backlog from the previous quarters, "I'll review them and I can give you the nod that you can publish them," because that's all that she was looking for, was somebody just to give that approval. Obviously bearing in mind the format and the type of stats, that decision had already been made and approved.

16. Then as the Use of Force Monitoring Group, as I started to become chair of that, we agreed that the quarterly external report, we would put it through that group just so there was governance to it, but ultimately it was the same type of stats that were getting reported every quarter, the type of information that was going to be getting reported. So, that was my involvement in that, and I believe since then they have been getting published online.

17. I have been asked about Police Scotland's external performance quarterly reports. By way of example, I have been shown the external performance report Quarter 1 for 2021-2022 (SBPI-00381). At pages 9 and 10, I can see that this provides a breakdown of the ethnicity of subjects recorded in the use of force forms. I have been asked about the comparison of the ethnicity statistics from these use of force forms on pages 10 and 11 of that report: "

Ethnicity	% of Population (2011 census)	% of UOF forms submitted Quarter 1 2022/23 YTD
White	96.0	93.6
Black and Minority Ethnic (BME) communities	4.0	5.1
Unknown	-	1.0

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The table above shows the breakdown of subjects ethnicity recorded on Police Scotland "Use of Force" forms for the period Quarter 1 year-to-date 2022/23 as follows:

- 96.0% of the population (according to the 2011 census data) was of white ethnicity, of the "Use of Force" forms submitted during the recording period 93.6% had a subject of white ethnicity
- 4.0% of the population (according to the 2011 census data) was from black and minority ethnic (BME) communities, of the "Use of Force" forms submitted during the recording period 5.1% had a subject from BME communities
- From the "Use of Force" forms submitted during the recording period 1.0% had a subject with unknown ethnicity, no comparison is provided to the 2011 census data"

18. I have been asked about these ethnicity categories and why the BME communities are considered as a whole when analysing the use of force data. I don't know. The decision about publishing it and how it would look, the format, was made before I came into post and I wasn't involved in those discussions, so that was in 2021. So when [REDACTED], sent me these to approve their publication, the reports were already in their agreed format. So in effect, all I was doing was actually sense checking that there was no errors. In effect, I was actually making sure that numbers tallied up, and just giving her that senior-officer approval to publish. I do know that the decisions round about publishing this were made at the Senior Leadership Board. I would imagine that there's potentially, I don't know, minutes or records of discussion from there. Whether any minutes would go into the detail of any decision made on this point, I don't know.

19. I have had sight of the death in custody toolkit (PS05141). I've been asked to explain my role in relation to this. I was one of the chief inspectors within Criminal Justice Services Division, which covers custody now. I can confirm the timescales but I think I started there in 2018, August/September time. When I was in that role, an opportunity arose for me to be trained as a post-

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incident manager. Now, I can't remember if this was the first course that the organisation were doing that was a post-incident procedure/manager's course for death in police custody and death or serious injury following police contact. Whether that was the first one, they were actually saying this is not just relevant for death following discharge of a firearm, or discharge of a firearm actually covers a number of other incidents in policing as well.

20. I know that the course I went on was a course that was PIP for death in custody or death following police contact, so it was an overarching one that wasn't just firearms related. That was the way the organisation was going. So that was the start of it. I was given the opportunity to go on that, particularly because I was a chief inspector within custody and, recognising that it's a high-risk area of policing.

21. But the post-incident procedure/manager's course was overarching. You didn't specialise in whether it was a death in custody, a death following police contact or a firearm. So that's where I think UK policing was going, so that's why I went on the course. Then having been in that course and, it was purely just from being a chief inspector in custody, made me realize that actually our people within the custody environment will be really unaware of what a PIP is. Our armed policing officers, with ARVs, you ask them what a PIP was, or it was going to be stood up, they'd be able to tell you. A lot of them would maybe be part of it. They'd probably get it in their training but, here we are saying that, actually, we're now introducing it for beyond firearms.

22. When I came back to the division from the course, I identified that actually our people won't know what this means. There's two reasons for that. One, it could have an impact on their wellbeing and welfare, in terms of, they could wrongly perceive that the purpose, and be concerned that they were a suspect, but also the second aspect is the first responders. So, for example, a custody sergeant who is not a post-incident manager, isn't aware of PIP, but is the first supervisory point of contact if a death in custody occurs in the cells.

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They need to know what they should and shouldn't be doing, so that they don't impact on the integrity of the wider PIP process.

23. So that was the start of it. It was purely from going on the course and then realising there was a gap within the division that I was working in. I need to make sure that our people knew what this was, knew what to do if a PIP was put in place and to give them appropriate reassurance round about it. So I raised that within the division up to the divisional commander, which was Gary McEwan who's now retired. Again, this is very summarised, and my recollection was that there was agreement actually. We need to educate people and we probably need to have a divisional process toolkit that people can refer to. It can be shared in advance, and can be referred to so they know what they're doing.

24. On the back of that, I chaired a working group that had various people involved from PSD who owned the PIP process, somebody from the Scottish Police Federation, operational leaders within the custody environment, really just to talk through how this toolkit would look, the development of the toolkit, what should be in it, making sure that whatever was in it was clearly obviously aligned to national PIP processes. Now, I had just been trained as a post-incident manager, fairly fresh, so I was quite confident that I had that knowledge, but I didn't own that process. So we had people from the organisation that owned and delivered the PIP training to make sure that everything that we planned to document and tell our people was completely aligned.

25. The training was run by Armed Policing Training in Police Scotland. So that was the department. It was one of the inspectors there - [REDACTED]. My understanding is it was always firearms focused originally, so that's the origins of that. I couldn't tell you now if it's still Armed Policing Training's responsibility, or if that's passed to PSD. PSD are responsible for deciding if

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PIP is going to be implemented for an incident, so I couldn't tell you where the organisation is with that. So that's how the training was delivered.

26. In terms of that toolkit, the purpose of it was to make sure that our people knew what the national guidance was in relation to PIP, but also so there was a local context to it. So, for example, the sergeant in the custody unit, if a death occurs, you phone this person. You need to be aware that PIP may be implemented, and therefore, don't do this. For example, do not start actioning your officers or yourself to give statements. So that was the reason for the toolkit. It's really more awareness and educating and, that was back in 2018, so I don't know how that's changed, what version it's now currently in force.

27. I have been asked whether, prior to 2018, whether there was there anything guidance or training which deaths in custody or following police contact. My understanding was there was a SOP for death or serious injury in police custody (PS11295), in terms of the approach to be taken round about welfare officers, the investigative approach, who had responsibility for that, CID until PIRC, whatever, but that toolkit was really focused on bringing the PIP aspect alive and making sure everybody was aware of that. I had no responsibility for the SOP relating to death in custodies. My recollection is it was not long after that that the organisation started to put comms out force-wide, recognising that actually a local policing officer could be subject to a PIP. So could an RPU officer. Such was the definition of what a PIP could apply to now, so that awareness raising and education started to come out from the organisation but, within custody, we realised it was such a unique division and the risk round about that, that we kind of just took the bull by the horns, so to speak, to start trying to educate and raising awareness amongst our own people.

28. I have been shown An Agenda for a PIP Custody Working Group (PS05138). It's dated 2 August 2019. I can see that I am named as the chair. Agenda item 4 is "visit to Metropolitan Police". I have been asked to explain what this was and its purpose. One of the other chief inspectors and I went down there

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just to get an understanding of how they implemented PIP, particularly in a custody setting. So it was to see if there was any particular learning from them that we could adopt up here when developing our toolkit and raising awareness and educating our people. So that was really just the purpose of that. I think we visited a custody centre and we spoke to a couple of people there. I think there wasn't a lot of additional learning that we thought we could bring into Police Scotland from what we already knew, having made changes - post-incident managers and what we were planning to do within the custody environment. That's my recollection, but it's also a number of years ago now.

29. I have been asked whether we made contact with the College of Policing, or any other organisations or police forces? I don't believe so, no, because we were following the College of Policing training at the time. Because obviously we were following their guidelines and approach to PIP that I had been trained on as a post-incident manager at the time, and what we were doing with the toolkit within custody was in terms of how do we make sure our people within custody know what a PIP was? So there was no proposed changes to actually how a PIP should be run or what a PIP looked like within custody.

30. It was really just to make sure that everyone knew what it was and what to do to actually maintain the integrity of a PIP process once there was a death in custody, because there's that period of time from when a person is found deceased in their cell, for example, and the initial actions that may start to get taken by the frontline supervisor whilst phone calls are being made, and up the chain to say, right, it's now a PIP, or a post-incident manager is being deployed. So it was to really try and fill that gap, particularly round about, so that a frontline supervisor knew what to do and what not to do. Because I think there'd been past experiences of potentially within half an hour, an hour, whatever it may be, of the officer starting to write full statements, for example, so it was really to try and just educate people on what they should and shouldn't do.

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31. I have been referred to an email chain regarding the PIP working group (PS05137). The first email is dated 1 August 2019 and sent by me to a number of the individuals on the PIP working group. One of these individuals is [REDACTED], whom I have mentioned earlier, he delivered my training, and was part of that working group; he was expert within Police Scotland on PIP. In the second paragraph of the email I state *“Please note, the Death in Custody Toolkit has been subject to Governance in CJSJ through our Operational Group and our Divisional SMT. It is not intended to detail the investigative considerations (which fall to PIRC) or indeed to detail the full PIP procedures, it is a revision of our current one page checklist for deaths in custody to more properly reflect recent developments and provide greater detail and clarity of role within the initial stages.”*

32. I have been asked about this checklist I am referring to in this email. My recollection was that there was a checklist for our frontline supervisors within custody to follow if there was a death in custody. I wasn't involved in developing that checklist. It was there when I came into the custody environment as a chief inspector in October 2018 but, when I saw it, it was clear to me that it was more a process-driven type checklist, i.e. what information to gather, who to contact. So when CID initially came, it came as a bit of a package of data, whereas clearly what my toolkit was trying to do was trying to take it beyond that and actually link it to, yes, a post-incident procedure because the organisation was now saying that PIP may be useful.

33. 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.

Date October 22, 2023 | 11:45 AM BST

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