The Sheku Bayoh Public Inquiry

Witness Statement

Philip Briggs

Taken by [redacted] at Capital House, 2 Festival Square, Edinburgh, EH3 9SU on 07 September 2023

Witness details and professional background

1. My name is Philip Briggs. My date of birth is in 1979. My contact details are known to the Inquiry.

2. I am a Civilian Member of Staff and the current National Lead for First Aid Training within Police Scotland. I am based at Police Scotland College, Jackton, and I have been in my current role since March 2022. I joined Police Scotland in 2001 as a Physical Education Instructor at Tulliallan before moving onto the role of First Aid Instructor in 2017 at Jackton up until my current role. I have been with the organisation for 22 years.

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Scottish Police Emergency Life Support (SPELS) and First Aid Experience: Qualification and Role:

Physical Education Instructor (2001-2017) - Involvement in Scottish Police Emergency Life Support (SPELS)

3. I am asked to outline when I became involved with SPELS training. I've been involved in SPELS from 2001/2002. I would have had some involvement from this point.

4. As I have been involved with SPELS since 2001/2002, I am asked to outline my involvement as at 2014/2015. Myself, along with two other colleagues (David Agnew and [redacted]), had the responsibility for the delivery of SPELS at probationer training at Tulliallan at that time. What happened everywhere else is unknown to me because the only people who received a full SPELS package were probationers at Tulliallan.

5. I am asked to outline my role and responsibility as it relates to the SPELS probationer programme in 2014/2015. The governance of the programme came from the OST team at Jackton. I am unsure what inspector was in place there at the time, but there was an inspector who sat at Jackton, and they had the responsibility for the SPELS programme, so any amendments to the programme would be directed from there. Our job (at Probationer Training) was to update the lesson notes and assessment materials, to make sure that what gets delivered in relation to SPELS was up to date as per the guidance that we were given.

6. In my capacity as Physical Education Instructor, I am asked to confirm if the probationary training that I provided during 2014/2015 was in accordance with PS12313 SPELS Lesson Note last amended 25 February 2014 which was in force at the time. I can confirm that any SPELS training I was delivering was in accordance with the current lesson note in place at that time.

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7. I am referred to Police Scotland's Position Statement 7 SBPI- 00357 SPELS on behalf of the Chief Constable of Police Scotland at paragraph 16, there's a paragraph that says:

   "The SPELS lesson notes formed part of a pack of material provided to probationers during their initial training at the Scottish Police College, Tulliallan. The SPELS lesson notes were provided to the course participants at the start of the SPELS module of initial probationer training, which was delivered in a block of four 45-minute periods over the course of one week. There was no pre-reading required of course participants before the SPELS module. The SPELS lesson notes provided the content for the SPELS training, which was delivered through classroom teaching or lectures to cover the theory followed by practical teaching, where techniques would be demonstrated to course participants, who would be assessed following completion of the SPELS module."

8. I am asked what my opinion is in relation to this paragraph, to expand on what was covered and to outline the structure of the SPELS probationary training in 2014/2015. I agree with this statement. The SPELS programme would be delivered over a half day ordinarily, accounting to 4 x 45-minute periods. The assessments would then follow in the days following. Depending on the size of the course it may take numerous inputs to train all classes in SPELS.

9. I am referred to Police Scotland's Position Statement 7 SBPI-00357 SPELS on behalf of the Chief Constable of Police Scotland at paragraph 17, there's a paragraph that says:

   "The aim of the SPELS training, as stated in the 2014 SPELS lesson notes (PS12313) is to allow course participants to understand and demonstrate the principal techniques involved in basic life support. The learnings outcomes as

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identified in those lesson notes were that at the end of the training, the course participants would be able to do the following:

a. Explain the chain of survival.
b. Administer basic life support to a casualty.
c. Conduct a casualty assessment.
d. Place a casualty in the recovery position.
e. Recognise and treat a choking casualty.
f. Recognise and treat a casualty who may be suffering from a heart attack.
g. Describe the correct method to control external bleeding.
h. Recognise and treat a casualty suffering from shock.
i. Recognise and manage respiratory distress in a casualty.
j. Recognise and treat a casualty who may suffer from a stroke.
k. Recognise and treat a casualty suffering from a seizure.
l. Describe an officer's actions at the scene of a water incident.

10. I am asked if I was able to cover all of the learning outcomes outlined within SPELS Lesson Note PS12313 during the SPELS probationer training in 2014/2015. I could. The programme was made up of 12 learning outcomes, which had been consistent for a number of years. A number of these learning outcomes were theory-based subjects (Chain of Survival, Bleeding, Stroke, Seizures, Respiratory Distress, Heart Attack and Shock), whereas others involved both theory and practical exercises (Basic Life Support, Casualty Assessment, Choking, Recovery Position, Water Safety). All 12 learning outcomes would be delivered, and students subsequently assessed by means of one-to-one assessment at the conclusion of the course. The delivery would sometimes be split between two venues, one being classroom based, focussing on theoretical aspects and the other being the practical aspects of the programme which would be delivered in a larger venue such as the OST arena or games hall.

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11. I am asked to outline what was covered in relation to 'recognising and managing respiratory distress in a casualty' during the Probationary Training in 2014/2015. The focus was placed on the identifying factors which affect people's breathing, primarily identifying Positional Asphyxia and the most appropriate management of this.

12. Further, I am asked to what extent was positional asphyxia and also excited delirium covered. Positional Asphyxia and Excited Delirium were both taught in OST, but Positional Asphyxia was also covered in SPELS at that time.

13. I am asked if I used any further learning materials or aids during the SPELS probationary training in 2014/2015 and to clarify if any of the training was scenario- based. I don't recall using any additional paper-based materials; however, I would use resuscitation manikins for the delivery of CPR training. Although scenario-based training wasn't directly used, I would utilise drills and exercises to build situations requiring students to consider best management of conditions. Certainly, in OST it would be common for me to introduce a Positional Asphyxia drill.

14. I am referred to Inspector Young's Statement SBPI-00153 at paragraph 47 where he discusses the SPELS Lesson Note PS12313:

"I'm asked about the first aid training which was provided in 2014/2015. The student officers at Tulliallan got their Scottish Police Emergency Life Support (SPELS) training package which there was lesson notes for. I can't actually remember how many hours was dedicated to that. I think it was potentially four, but I can't be sure. But that was a standalone first aid training and was along the lines of basic life support. So, we talk about the chain of survival, basic life support, conducting casualty assessments, recovery position, choking hazards, how to treat choking, how to identify heart attack and control of bleeding. I think dealing with stroke and seizure were also involved and water safety. So, all student officers received their SPELS training, their basic

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life support training. They had to pass an assessment on that. That was conducted by a cadre of qualified first aid instructors separate to the OST. So, it was basic life support, basic identification of casualty assessment and then actions to be taken."

15. I am asked what my opinion is in relation to this paragraph and if I have anything else to add. I agree, but I would like to clarify that SPELS training was 4 periods in the timetable, which equated to 3 hours. Additional periods on top of that were used for assessments.

16. I am shown PS12109 Probationers Training Division Standard Operation Procedures: SPELS Assessment Guidance and Questions dated 21 July 2010. I am asked if I recognise this material. I do recognise this document.

17. I am asked if I could talk through what the material is, how it was used and to comment on its effectiveness. This document supported the assessors in guiding them through the administration of a SPELS assessment. It is a document that would likely be useful as it helps towards consistency of assessment.

18. I am shown PS12108 Probationers Training Division- Standard Operating Procedures- SPELS Assessment Guide dated 21 July 2010. I am asked if I recognise this material. I believe I do.

19. I am asked if I could talk through what the material is, how it was used and to comment on its effectiveness. Again, it was to ensure consistency of assessments by guiding assessors through the correct administration of a one-to-one assessment. In my opinion it would have been useful and effective.

20. I am referred to Police Scotland's Position Statement 7 SBPI-00357 SPELS on behalf of the Chief Constable of Police Scotland at paragraph 18, there's a paragraph that says:

"The assessment for SPELS was done by means of an oral examination and by way of a practical test. Each student would be assessed individually. The course participants would be asked a series of questions as a knowledge check and would be asked to demonstrate practical skills that had been taught. PS12107 is the SPELS assessment form (v4 dated 19 September 2011)9 that would have been completed for each course participant, who would be required to demonstrate knowledge and competence in the following areas:

a. Management of a choking casualty
b. Recognition and management of a heart attack
c. Control of external bleeding
d. Shock and internal bleeding
e. Recognition and management of respiratory distress
f. Recognition and management of a stroke
g. Recognition and management of a seizure
h. Water safety
i. Practical Skills (Adult CPR Skill application)
j. Practical Skills (Recovery position)

21. I am asked what my opinion is on this paragraph and to expand upon this if I have anything else to add. I agree with this statement.

22. I am shown PS12107 SPELS Assessment Form dated 19 September 2011. I am asked if I recognise this document. I do recognise this document.

23. I am asked if I could talk through what the document is, how it was used and to comment on its effectiveness. This SPELS assessment form was utilised by the assessor during the one-to-one assessment and allowed each element of the assessment to be marked as pass/fail. In my experience it was extremely effective and running assessments without a document such as this would likely have reduced its effectiveness and consistency.

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24. I am asked, in my opinion, was the SPELS probationary training adequate and fit for purpose in 2014/2015. I believe so, yes.

25. I am referred to Position Statement 7 SPELS SBPI-00357 on Behalf of the Chief Constable of Police Scotland at paragraph 28 and 29 which comments SPELS Lesson Note PS12313 and Recertification training:

> *"The SPELS lesson notes for probationers were not used in SPELS refresher training. However, the SPELS refresher training would cover practical skills (CPR and recovery position) as well as the medical emergencies that officers might encounter, such as Positional Asphyxia, as set out in the SPELS lesson notes.*
>
> *Prior to 1 September 2015, when the online learning platform, Moodle was introduced for e-learning, it was understood that officers would access 'SPELS' material via Legacy arrangements on the 'Local Applications' tab of the intranet".*

26. I am asked what my opinion in relation to this paragraph relates to SPELS recertification training. I'm unaware of how SPELS was being delivered on Moodle as it was not a platform in use in probationer training, so I can neither agree nor disagree.

27. I am asked to outline what SPELS recertification training looked like during 2014/2015. Outside of Probationer Training at Tulliallan, to my knowledge nobody trained the full course in one training event, such as a full class. At the start of a refresher course, Resuscitation manikins were placed around the venue, instructors would demonstrate CPR and- students would then have some practice of CPR on that. The Recovery Position was also demonstrated by instructors and practiced by students. Generally, I think that was the limit of the first aid practical training at that time.

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28. I am asked if students were assessed for the SPELS recertification in 2014/2015 for example, was it pass or fail. There was no assessment during the recertification that I was aware of. When CPR and the Recovery Position were practiced, the assessors or the instructors would keep their eye on the group, but there wasn't a pass-fail attributed to that part of the programme that I was aware of. It was down to the instructors to monitor groups as appropriate. However, I was based at Tulliallan at this time so it may well be the case that assessments took place that I was unfamiliar with.

29. I am asked what training instructors providing SPELS training to students receive. Instructors did their First Aid at Work Course every three years, as is standard for that course. FAW for instructors means we train them to the highest level we have in training. Primarily it is to ensure that training venues have appropriate first aid coverage and also ensures that our instructors have a good knowledge of general first aid.

30. I am asked to outline how the online platform Moodle factored into the recertification training in 2014/2015. I was never cited on the Moodle package because we never did it at the Tulliallan. To my knowledge it was only used for recertification, but there were assessment questions that were embedded into that programme. Where the questions were positioned within the programme I don't know.

31. I am asked if there was any specific monitoring of Moodle. Not as far as I'm aware, but this was out of my area.

32. I am asked, in my opinion, was the SPELS recertification training provided in 2014/2015 adequate and fit for purpose. No, I don't think that Moodle was the best model to follow for delivery of what is a physical programme. It is my belief that if it's physical training that's required, that's not theoretical and it should be primarily physical trained. If it's physical training, it should be a physical action for training. I think everybody recognised it probably wasn't fit

for purpose. However, we had no data to suggest that Moodle wasn't fit for purpose.

First Aid Instructor (2017-2022)

33. I am asked to outline how I came to be in the role of First Aid Instructor at Jackton. An opportunity presented itself when Wendy White left this post, and it became open. For personal reasons, it made sense to move into this role within Jackton at the time.

34. I am asked to outline my main role and responsibility as a First Aid instructor. At Jackton, there was either a two-day First Aid at Work (FAW) course per week or a three-day FAW course per week. These differ from SPELS. The majority of my time was taken up with the actual delivery of these courses. Some of the other things which came within the remit of that role were the maintenance of the FAW programme and helping out other trainers around the country who were part-time first aid trainers; trainers who had more than just first aid as their responsibility. There wasn't any supervisory capacity to the role but being the only dedicated first aid instructor, the emphasis was placed upon this role for maintaining the programme.

35. I am asked if the First Aid at Work Course sits separately to the Scottish Police Emergency Life Support (SPELS) programme. Yes, the two programmes sit separate. So, you've got SPELS as it was. Every operational officer up to Inspector would get that training, including civilian custody staff. The First Aid at Work package, either three-day for the initial or two-day for refresher, sits separate from that and that course would be aimed for those that require First Aid at Work training as per Health and Safety Executive requirements. For example, our custody staff would receive FAW training. Staff who work in a larger office in which health and safety require that level of qualification to be present within the building. First Aid instructors would also undertake this course every three years. So, I had the two programmes on the

go. The first aid training role at Jackton didn't really cross over into SPELS that much as that was considered a different department at that time. As both FAW and SPELS train very similar content there will obviously be alignment at certain points, but they were considered two separate courses.

36. I am referred to my role relating to the delivery and maintenance of the First Aid at Work programme, and I am asked to expand on what is entailed in the maintenance of the programme. I would continue to do assessment of the programme, coaching and mentoring of instructors and when required adjust and update materials.

37. I am asked how I assess if a programme requires to be updated and if I would receive any support carrying out this assessment. From 2017 onwards, we had our clinical advisor, Dr Richard Stevenson that came into the role. Dr Stevenson was able to give us clinical guidance as to what should be trained and how in his opinion to make sure everything was medically sound, but the majority of the First Aid at Work programme was a pull across from the voluntary sector first aid manual (St Andrews, St Johns. Red Cross). First Aid at Work programme are defined by the Health and Safety Executive, so similar content was followed.

38. I am asked if there would be regular meetings with Dr Stevenson to discuss what material requires updating or has evolved over time. Yes, we would have an open communication in that regard. If we thought something required consideration or a medical opinion, we would discuss. In training we have three resources that we can base our programmes from have, namely the UK Resuscitation Council who review first aid guidelines every five years. We can also utilise Dr Stevenson's expertise for further or alternative guidance, and also any published work from a medical source. From these resources we can determine what would be beneficial to deliver in the programmes. We obviously use Dr Stevenson's expertise, whereas before he began working

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with us, we didn't have any sort of clinical advisor working with us that I was aware of.

39. I am asked if I was responsible for or involved in any strategic decision relating to when materials were examined for relevancy i.e., what is included and what isn't included in the programme. No, at that stage, the only role I would have regards to that is to make suggestions to line managers.

40. I am asked if I would have meetings with the line managers to discuss the training programme. Wendy (White) had initiated progress in this regard. Wendy had tried hard and made good inroads with aligning the First Aid at Work programmes for all the areas in Scotland, whereas from 2013 through to that point, there were still legacy structures for training in existence. Not everything was able to transfer at the same time. It seemed that First aid at Work was one of those courses. Wendy, to guess in 2016, had started to make all those inroads to making sure that everyone was teaching the same topics from the same materials. When Wendy left that FAW programme, it was closer to the product I think she wanted. When I came in, it was my role then to make sure it proceeded to the point where we had ourselves training to a set standard.

41. I am asked if I am aware of if Wendy was instructed by anyone to begin the process of standardisation. I would imagine her immediate line manager at the time would have done it. The process for which I'm not certain of because I was at Tulliallan at the time.

42. I am asked what training and qualification I undertook for my role as a First Aid Instructor. In 2001 when I started the job, the remit of a physical education instructor was quite narrow. It was physical education, and it was first aid and that was the two major subjects within that role. It probably would have been soon into my employment in 2001 that I started shadowing existing trainers. In 2002, I will have gone through a process of a training course or a sign-off from

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experienced instructors and that led me into becoming a First Aid Instructor. Thereafter, it was just a matter of retaining current knowledge and just continually training all the way through. This will be reflected on my Scope record.

43. I am referred to Police Scotland's Position Statement 8 SBPI-00358 Training on behalf of the Chief Constable of Police Scotland at paragraph 78, which says:

"The First Aid Manual, dated 29 July 2014, was not part of initial or refresher/ recertification training material. However, it was part of the training material provided to those officers and staff who underwent the First Aid at Work course."

44. I am asked if the FAW training provided in 2014/2015 was in accordance with PS12384 First Aid Manual revised July 2014. As I didn't deliver FAW in my previous role at Tulliallan, I'm unable to confirm if that was the case.

45. I am asked to provide an overview of what was covered for the instructors in 2014/2015. As I was in my previous role at Tulliallan, I'm unable to provide any information on this.

46. I am asked if the training covered Excited Delirium and if so, to what extent. When looking back at the previous FAW manuals, Excited Delirium was not represented in this programme.

47. I am asked if the training covered Positional Asphyxia and if so, to what extent. When looking back at the previous FAW manuals, Positional Asphyxia was not taught in FAW.

48. I am asked, in my opinion, was the training on FAW adequate and fit for purpose in 2014/2015. As I wasn't delivering the programme then, I'm not well placed to provide an opinion.

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First Aid Training National Lead (2022- Present)

49. I am asked to outline my role and responsibility as First Aid Training National Lead which is separate from Operational First Aid. I am also asked if it was accurate to say that Operational First Aid has replaced Scottish Police Emergency Life Support (SPELS), First Aid at Work (FAW) and Emergency First Aid at Work (EFAW). So, Operational First Aid replaced SPELS only. Although Operational First Aid replaced SPELS it wasn't representative of my role in full. SPELS has been in place for a long time but wasn't particularly well thought of in terms of how it was delivered.

50. I am asked to explain why SPELS "wasn't well thought of". It was delivered over something called Moodle, an online training platform. So that's away from Tulliallan. Probationers get SPELS training face to face, whereas those officers and staff undertaking recertification got a Moodle package. I was never cited on Moodle because it wasn't used at Tulliallan. So SPELS wasn't well thought of. I think cops didn't really see the benefit of how it was delivered in that way, but that's as it was until I came in to post. So yes, since I've been in post, we've introduced operational first aid, which was a direct replacement to SPELS and that formed part of the officer safety programme, officer safety training. Then First Aid at Work, again, kind of sits separate to that. So, we've still got the two separate programmes, and who goes on what programme is really structured by their job role and what they need.

51. I am asked to clarify where the Emergency First Aid at Work sits within training. It's almost like half of the First Aid at Work programme. So, again, it's something that's out in the private sector as well. The health and safety executive have two First Aid at Work programmes, Emergency, which is a one-day programme which stops short of moving into medical conditions. It really just stays at emergency, as the name would suggest.

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52. For avoidance of doubt, I am asked if the Emergency First Aid at Work programme covered Acute Behavioural Disturbance or Positional Asphyxia. No, the only programmes that go into that are the operational first aid or old SPELS, because those were police specific required for training. So, we had it in that programme but not necessarily First Aid at Work.

53. For the avoidance of doubt, I am asked if the Emergency First Aid at Work is more likely for staff rather than operational police officers. That would be a good way to put it. We don't train many people in Emergency First Aid at Work. I think last year we trained probably less than 20 in the whole force, very few people qualify for it. Most people will either do the Operational First Aid programme or they'll qualify for the full First Aid at Work programme. It's down to line managers to make their assessment of what course might fit best, but we don't tend to use it for that much.

54. I am asked how I came to be in this role as national lead. So, that was something that I had to push at quite a lot. There was an understanding from myself and line managers that the role that I was doing was not simply a first aid trainer. It was a national lead in essence because of the amount of responsibility I was taking for programmes. It was a fight to get that new post created. There was nobody looking after these programmes at a trainer level. It was all inspectors that had responsibility for them.

55. I am asked if this role is equivalent to Inspector Young's role when he conducted his national review around 2016. No, as I fall under an inspector at present, so that role sits similar to a sergeant's role in that kind of structure. I am asked who my inspector is at the moment. So, at the moment it's Inspector David Bradley. And he is the head of Operational Safety Training and First Aid. So that's how it branches off and I'm off to the first aid side of that business area.

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56. I am asked if this role was created for me based on what my remit was at the time. Yes, that's right.

57. I am asked what qualifications I have to undertake for this role. There weren't any additional qualifications required for this post. It was still in line with what the first aid trainer was and what the physical education instructor was. So, I was educationally qualified. So, the base level for leadership and training development at the time was a diploma in education, this was run by staff at Tulliallan within the Napier University structure, and I received a certificate from Napier University. So that was the base level I sat with and then I extended upon that and did a degree in Education, or what was called the training qualification for further education. It's something called TQFE. It was a one-year programme run by the University of Stirling which I did alongside my job, but that degree qualification isn't required for the job. This will be reflected on my SCOPE record.

58. I am asked if I regularly undertake recertification training for this role. Yes, the same as everyone else, the basic qualification for being a first aid trainer is First Aid at Work qualified. So that's a three-year qualification and every three years you need to go back through refresher training. So even the likes of myself will still go through that process.

59. I am asked if the national lead is my main role at the moment. Yes. So, all first aid training- sorry, when I say all first aid training, that's not entirely true. There are still specialist units, such as public order and firearms, and mountain rescue. Their governance for first aid comes from other areas so I don't have a role with them.

60. I am asked to outline my role and responsibility as national lead for first aid training. I've got responsibility for the two programmes: the First Aid at Work programme and the Operational First Aid programme.

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Responsibility for First Aid at Work Programme

61. Firstly, the First Aid at Work programme has been in existence for a long time, and it's not changed huge amounts over the time that I've been in position. I have responsibility for retaining, updating, adjusting the First Aid at Work programme, preparing all the documentation, and then the supervision and the assessment of trainers who deliver that programme. However, I do not have line manager responsibility for anyone because there's no full-time first aid trainers. Essentially, I could still be a full-time first aid trainer, but I don't have the time and capacity to do it.

62. I am asked to expand on my role as it relates to updating the programme. So, we work with our quality assurance department. We've got a quality assurance framework that we work towards, so we'll carry out teaching observations at least once a year on each First Aid at Work instructor and that's just an overview of how they're delivering the programme plus relevant feedback.

63. So, we've got six sites that deliver First Aid at Work. We've got Jackton, which about half of all courses run from there. [redacted] in Edinburgh. We've got the Scottish Police College. We have [redacted], a place called [redacted], and [redacted], a place called [redacted], and then [redacted], a place at [redacted]. It's not to say that training courses won't happen out with those areas. Sometimes it will move into other suitable areas, but that's the primary six sites that get used and there's trainers within those venues.

64. I am asked to outline what is involved in supervising and assessing the trainers at the aforementioned locations. So, it's obviously seeing the programme from start to finish. It's observing and assessing the delivery of the 14 modules in First Aid at Work. Basically, we're going through each module, watching for how it's getting delivered, seeing that it's close to the lesson plan, making sure that everything's delivered as it should be and then

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making suggestions about things which could improve the delivery, potentially. What we obviously try and do is get internal verification done on the assessments.

65. I am asked to clarify what I mean by Internal Verification. So, we've got an Internal Verification framework, and what we look to do is achieve a 10 per cent return on each assessor's assessments. I primarily do it, but I have got two other experienced trainers in different geographical areas that will also be able to do Internal Verification, which just splits the country down a little bit easier, rather than me going everywhere.

66. So, what we'll do is we'll go out, sit in a corner, watch over an assessment taking place, without getting involved, and what we're doing is monitoring how the assessment is run by the trainer and then making a judgment based on what we see, "Have they assessed that correctly?" So as per the guidance which has been given to them, as per the form that they utilise for the assessment. This is part of quality assurance process.

67. I am asked to outline the process for adjusting and updating manuals and documents. So again, we don't do it often. I'll see a need or an opportunity to update areas of the programme and will consult with Dr Stevenson. Sometimes we consider things from the sort of meetings that we'll have, most of which are either a phone call between us or a quick message. For example, if he tells us that there's a new change medically about some techniques which are no longer considered appropriate or might have adjusted, so that's one method that it might come to me. The UK Resuscitation Council, with their five-yearly adjustments to their programme, that can also lead me to make changes.

68. I am asked out with Dr Stevenson's consultation do I personally review for updates as well. Yes, because it's my responsibility, I've always got eyes on what the programme should have, and if any inclusions should go in. I'll take

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responsibility for that. So, the most recent example was just before summer, and I changed a couple of things with the First Aid at Work programme to align with the operational first aid course more closely.

69. So, there were things that when we adjusted the Operational First Aid Programme to teach trauma to a higher degree. First Aid at Work needed to match that, otherwise we'd end up with two programmes that sit too separately apart from each other when really, they need to align whenever alignment can take place.

70. I am asked if I aim to ensure that there is consistency between the two programmes. As best as possible, yes. There'll be some topics which get taught in one programme and not the other but the judgment for that is based on what is required from the group of people who will be subject to that training.

71. I am asked if there are any panels or advisory group that I sit on to obtain guidance from Clinical Advisor Dr Stevenson for this programme. Yes, we have a Clinical Governance Group, and that's solely set aside for first aid. That's chaired by an Assistant Chief Constable, and then plenty of business areas have got a seat at that table for that meeting, including some external partners, such as the Scottish Ambulance Service, Unison, Optima Health, and the Scottish Police Federation.

72. I am asked to outline the purpose of this group. It's to retain governance over all first aid issues within the force, including the first aid training programmes, plus any first aid issues out with training. The terms of reference for that group are essentially to make sure that everything is current and valid and that the force is doing everything that it should be doing. We meet quarterly, ordinarily.

73. I am asked if the group monitor the overall direction of First Aid at Work. Yes. There are not many things that need to come to these meetings from First Aid at Work because it's quite a settled programme. There are not many things

that adjust in that. The Operational First Aid Programme there'll be more; discussion might come up about that when we're looking to adjust the programme.

Responsibility for Operational First Aid

74. I am now asked about my role and responsibility for Operational First Aid. Operational First Aid, it's part of the programme of Operational Safety Training, so the responsibility is on myself for that one. When we adjusted it for a restart this year (2023)—it was my responsibility to write all the materials and documentation for it and then train and mentor all the trainers, or as best as possible because there's quite a lot of them. My responsibility is really the whole programme. There is obviously the inspector that sits above me, Inspector Dave Bradley, who takes an overview of the entire programme, Operational First Aid being a section of it. It's pretty much the same alignment to my role with First Aid at Work. There's not a huge amount of difference. The only thing I've not really managed onto yet is quality assurance of the first aid programme because we're still quite new into it, [redacted] I've made mention of earlier on. Other people have been moving around the country to, sort of, keep an overview and support trainers when they're delivering that programme.

75. I am asked to clarify when the Operational First Aid new programme was introduced. Work has been ongoing for quite a period of time. We formally launched this current programme; I think 20 March 2023. So that was the most recent adjustment.

76. As my role is a newly created role, I am asked if it was part of my remit to launch Operational First Aid as the new SPELS. It was part of the understanding, although much of the initial work began before my role officially changed. There had been a change in the programme before that when we'd started to introduce something called "pressure bandages," when

there was just a requirement just to teach a little bit more, so that had already started, but there was a knowledge that we needed to do a full rewrite on some of the topics. That was primarily due to the London Borough attack and the Manchester bombing. The inquest from those basically came out and said, “Police services should be trained for trauma, and they should be equipped for trauma.” So as soon as that came out, that was our lead to push towards a more trauma-based programme.

77. I am asked to expand on my reference to inquests that propelled this change to the programme. Yes. I mean, I didn’t have complete responsibility for doing that. That was more, sort of, in line with Inspector Bradley, and those things went to the clinical governance meetings. So, when we looked for a change, we would give a brief explanation to the clinical governance group about what we intended to do and why, there was two things we needed to do. One was look at those inquests, and the other one was look at the number of cops who were getting hurt, like badly hurt. So, I think over the space of three years we had cops injured, like stabbed or hit with machetes or hit by cars. I think it happened on four occasions in three years, so we needed to make sure that the training aligned to the possibility of these injuries taking place.

78. I am asked to outline the quality assurance process for the new programme, and I am asked if Dr Stevenson was involved in this process. Yes, so whenever programmes get amended, the materials will go to Dr Stevenson, and we’ll normally have, if possible, a face-to-face meeting, but obviously during COVID, a lot of things took place in other forums. But before we launch, he gets given all the materials for it, just for his critical overview and if he effectively looks at something and suggests that we shouldn’t be training that or, “pick something different,” but he gives us that top-level medical advice.

79. I am asked if Dr Stevenson proposes a removal of a section for example, who is this referred to for a decision to be made. Often, if it’s quite low-level, it’d

just be me. Significant work would go through Inspector Bradley and perhaps even taken to the clinical governance group.

80. I am asked where Operational First Aid fits into the wider training structure of Police Scotland, from a probationary and recertification point of view. So, it has been pushed far more than it ever has been before, so it's become a higher priority in my opinion, whereas before I had the feeling that it perhaps wasn't given as much substance as perhaps it could have been. Where it is now, it's a good product now, in my belief. So, if we start at the college for probationers, it's now a full-day training package, whereas previously it was a half day. Assessment runs very similar to what happened before. There's now a little bit more in it. It's assessed summative at the college, so very similar to First Aid at Work. It's a one-on-one assessment sing a sheet which advises the assessor precisely what they need to see or have said back to them, based on their questions. The assessment is at the end of the programme. For the recertification programme. very similar takes place. It's one-to-one assessment and again the assessors have got their bank of questions that they'll utilise, and all the physical actions need performed. We are currently looking at moving that to formative however, or some of it moving to formative assessment.

81. I am asked if I was responsible for or involved in any strategic decisions relating to Operational First Aid. The overall responsibility sits with Inspector David Bradley. I report to him so any amendments at the moment towards the Operational First aid Programme, he'll be cited on it because that's still quite a new programme, if you like, so any adjustments are still working through that at present.

Signature of witness…… [redacted] …….

First Aid Instructors Meeting Minutes 08 May 2018

82. I am referred to PS13117 First Aid Instructors Meeting Minutes from 08 May 2018. I am asked if I recall this meeting. Yes, I chaired this meeting. I am asked what the purpose of this meeting was. This is only dealing with First Aid at Work and not touching on SPELS. The people in attendance were those who delivered the First Aid at Work programme. That is with the exception of [redacted] and [redacted]; they were line managers for First Aid at that time. Everyone else that was on there was an existing trainer of First Aid at Work. So, what really hadn't happened before is we didn't really get together as groups. I mean, this is still 2018, so we were still in the process of finishing off the sort of work that Wendy had started. I think Wendy had done a couple of these meetings as well before it, in 2017. It's quite possible.

83. I do remember sitting in one that she chaired, and that was, like, the very first time trying to bring people together. So, this particular meeting, I seem to remember it, when I went through the documentation, that it was quite a big one, as in a lot of work had been done on the First Aid at Work programme and particularly with standardization, and it was to bring everyone together, update everyone on all the things that were happening, and just try and align things as best as possible, and let people know where the movements are, and importantly, why changes are made, to try and break down all the legacy structures which people still perhaps thought on.

84. We never had terms of reference formally for it, it's really to update the trainers about what adjustments might come in, what, sort of, quality assurance is going to look like from this point forward, and just anything else which is relevant. So, I think there'll probably be mentions on SPELS, for example. So, although they don't teach SPELS, there's crossovers, so it's just an opportunity to update everyone on all the work that was going on, and the vast majority of all the work that was going on was mine.

Signature of witness…… [redacted] …….

85. I am referred to paragraph 10 of PS13117 titled ‘SPELS Assessments’ which outlines as follows:

“Improvements in assessment process for the initial SPELS course (SPC and Specials Training) were presented, along with the updated paperwork which is to be used from this point forward. The improvements were made in line with the recommendations made by Q.A. following their report on the existing process.”

86. I am asked if I recall the discussion surrounding this section. So, when I was still at the college, I think quality assurance had come in, as they’re meant to do for all courses, and done some external verifying for the programme, and had come up with some suggestions about ways that it could be made better. I believe the things which came up from that might have been to make sure there was consistency of approach as there was often a number of different assessors looking after a large group so it might have been that some assessors asked more questions of a candidate versus somebody else, so that will have displayed a lack of consistency, and perhaps it’s something you’re going to show me but I think there was a document produced which was overall guidance for assessments of SPELS.

87. I am referred to paragraph 11 of PS13117 titled ‘SPELS review’ which outlines as follows:

“A brief update was provided in relation to the SPELS programme. Although not all instructors deliver this training, it was considered pertinent to raise this as an item as it can be expected that as the first aid instructors within their area(s) they may have to provide support to those who may be delivering the SPELS course. Furthermore, the alignment of SPELS to all other First Aid training should be monitored to ensure that potential conflicts are managed.”

Signature of witness…… [redacted] …….

88. I am asked if I recall the discussion surrounding this section. So, that would be something that I would have taken on, and it was just about due diligence. Although we perhaps couldn't align the programme because that would make them the same, it would be to ensure that we're not teaching something differently in one programme than the other, because we do get some people who get trained in both programmes. So, every three years, they may get First Aid at Work, and every year they would also SPELS, so it was to try and make sure that, when SPELS was going to adjust, that I made sure that First Aid at Work training wasn't going to go off on a different tangent.

89. I am asked if these two paragraphs mean anything to me in terms of how SPELS and First Aid at Work training moved forward from this point in 2018. Aside from training delivery, my main focus at this point was on accuracy of the programmes in relation to each other to avoid conflicts or unnecessary variations between them.

90. I am asked if there are any other points that I'd like to add in relation to this meeting. The only thing I would add into these sorts of meetings was these are roles that I was taking as the most interested party in first aid, rather than it being my responsibility, but I had line managers who had responsibility for the actual programme if you like. But I wasn't in the role I am now.

Review of Scottish Police Emergency Life Support (SPELS) Programme in 2014

91. I am asked if I was responsible for introducing the new SPELS programme in 2016. I would have been part of the instructional team who introduced it at probationer training only. My involvement would not have included any of the development work on the programme.

92. I am asked how the new programme came about. This was as a result of [redacted] report PS12110 ('SPELS Course Evaluation Report' dated

02 October 2014) we'd been directed as to what changes needed to go in or needed taken out; it was primarily moving things out. It could have been any of the three of us – myself, [redacted], or [redacted], or indeed any of the other instructors – but I run quite a lot of the SPELS stuff because of my interest. The lesson notes needed updated. The lesson notes go into the full booklets that probationers received, so it was to make sure that those were updated. So, because there wasn't really-- to my knowledge, there wasn't really SPELS notes elsewhere, because nobody got trained in it to the full degree, we at the college were the only ones who held an actual physical document for lesson notes so when the adjustments were made to the programme, the college needed to update our materials, and I would likely have done this.

93. I am referred to email PS12874 dated 29th September 2016 which enclosed a draft SPELS Lesson Notes. This email was sent along with its attachments to Inspector James Young, Head of National OST at the time and Wendy White, First Aid Instructor/Co-ordinator at the time. I am asked if the above roles are correct. Yes, the email shows as having been sent to both Jim and Wendy however, in fairness to Wendy, her role was what I took, which was solely a First aid Instructor and was not co-Ordinator. There was no responsibility outside of training delivery.

94. I am asked to clarify if Wendy wasn't the National First Aid Co-ordinator at the time. No, and that's where a lot of our issues, starting with Wendy and myself, over a number of years, just morphed into responsibility based.

95. I am asked to clarify, for avoidance of doubt, whether then it is the case that our roles were expanded in responsibility but not in name. Yes, I think that's fair. We had more of an interest than perhaps those who had responsibility, and the skills which allowed us to move out with our roles.

Signature of witness…… [redacted] …….

96. The email says as follows:

"I've drafted a new set of notes for SPELS. It's basically a rewrite, which aligns the best part of our notes with the new material from yourself and text from Wendy's manual. I've sent it round the instructors here for comments and alterations at this stage. Could you please also case your eye over it and see if it meets your expectations."

97. I am asked what notes I am referring to in this email. That will be the First Aid at Work manual. Wendy, I think she basically wrote one when she started, because a national one didn't really exist for First Aid at Work. Wendy authored the first, First Aid at Work Police Scotland manual. I assume there would have been previous ones, which would have been legacy force ones. So, yes, based on those two sentences, when I updated the notes for SPELS, it was to make sure that what was in Wendy's document matched what was in the SPELS documents, where appropriate. The notes in relation to Inspector Young relates to the Lesson Notes that go into the probationer training folder.

98. I am referred to email PS12874 dated 28th September 2016 which enclosed a draft SPELS Lesson Notes which was sent to OST, SPELS and First Aid at Work Instructors. The email says as follows:

"As is becoming ever more important, all training delivery and materials around the country must be consistent, which was another action from the report".

99. I am asked whether the purpose of the review was to standardise the SPELS programme. Standardisation should be achieved regardless. So, no, my understanding from this was just to make sure that the programme was in line with the most recent report or as given to us by the inspector, which at the time probably would have been Jim, but I think he'll be acting on the work from [redacted]

Signature of witness…… [redacted] ……

100. Further down in my email to the instructors, I have said:

"The report indicated that the programme was to be updated. Out of the curriculum go:
Seizures
Water Safety (now covered in OST)
Stroke
Respiratory Distress
New inclusions are sections on Defibrillation, Positional Asphyxia and Acute Behavioural Disorder (ABD)"

101. I am asked what the reasoning was behind what was included and excluded from the programme. It was on the basis of [redacted] recommendation. His report, PS12110 'SPELS Course Evaluation Report' dated 02 October 2014, I think he based it on what the cops deal with, and I think those are the things which he identified are not dealt with to a significant degree and that guided his opinion or guided his direction to the rest of us as to what should be amended. Defibrillation, obviously, in the private sector that has existed for a little while, but it didn't go into First Aid at Work programmes until 2015. I think the Resuscitation Council started making directions that defibs should form part of First Aid at Work courses, whereas before it was a separate programme all by itself. So, what may have happened is Wendy's perhaps advised [redacted] to bring defibrillation and CPR together. My understanding or through memory is that positional asphyxia and acute behavioural disorder – as it was then, disturbance now – they were always in the OST programme, but I think the decision at this point was made to manoeuvre them into the first aid aspect because of the first aid nature of the two things.

Signature of witness…… [redacted] …….

The Replacement of SPELS and the introduction of Operational First Aid

102. I am asked where is training on SPELS at present. We replaced SPELS with Operational First Aid. So, the majority of the programme didn't look hugely different, but it was a philosophy change to get rid of SPELS which as a term wasn't well liked.

103. I am asked why this was the case. It's anecdotal from what cops who told us. SPELS became, I think, partly because it was online, people didn't give it its due. It didn't seem to be structured in a way which people engaged with particularly well. So, our big change was, well, if we changed the title of it, it looks like a rebrand. Effectively, it was a rebrand right from the very top, and then it was to get it off online and all into a training venue.

104. I am asked, in my opinion, has this change affected the adequacy of training. Yes, we're happy. The feedback from learners is very positive, especially when compared against what went before, and some of the data that we're getting from the casualty treatment reports which is quite a recent thing. We're starting to get information in about whenever first aid's been used and over the last couple of weeks, we've had a couple where tourniquets have been used, but a serious incident back in these days, unless somebody was coming out of the military, probably wouldn't be familiar with the equipment or how to use it. So, when we look at sections like that, it paints the picture or paints the programme as we've currently got it in a very favourable way.

105. I am asked if there was a reason behind the decision to keep track of when first aid is being used. It was considered best process. It started off from England and Wales. A few forces down there had already begun with their idea of capturing data. Most forces were encouraged to follow something similar. It was the right thing to do. The whole idea behind it was so that data could actually guide training and equipment, whereas before we

were utilising our notes from what had gone before and we were using it from the UK resuscitation council and almost treating it like general first aid; the data now tells us what is getting used, and it will allow us over time to adjust our programmes to match what's actually getting used.

Clinical Governance Group

106. As I currently sit on the Clinical Government Group, I am asked to outline the purpose of the group. So, it got set up in, I think, 2017. There was nothing before that that I was aware of, so it meant that decisions for first aid training, first aid provisions etcetera, it was very localized. There was an understanding that clinical governance should take place and all those who have an interest in first aid should be represented at this forum. So, part of that was to bring a clinical advisor in, and that was when Richard Stevenson began with us, round about that same sort of time. I think it started in 2017. When the first clinical governance meetings started, I don't know what the date of that original one-- but we are in 2017 when we start looking at putting processes in place.

107. I am asked who the members of the group are. So, not highlighting in level of importance, it's normally an Assistant Chief Constable who chairs it. Then, we start with ourselves in training. Health and safety will be involved. The Scottish Police Federation will be involved. The Ambulance service are normally involved. Different divisional units, so for example, custody, firearms, mountain rescue, public order: so, representatives from all areas are invited to attend.

108. I am asked what sort of discussion we have within the group and what kind of output do we have. So, there's a rolling agenda. I forget the exact running order, but Learning, Training and Development will have a section where it's just an update of where we currently are over the last three months. Public order will be asked the same thing. Quite often it will be a nil return

from some areas, if they've got nothing that they want to update the group on, and then there'll also be sections set aside for specifics. So, if there's specifics, that'll normally be presented in advance in the form of a paper which goes out to the group, normally at least a week if not two before the meeting, so that everyone's understanding what's going to be discussed. So, the rolling agenda exists, plus any specifics from any group.

109. I am asked how often we meet. It's every three months, or it's intended for every three months.

110. I am asked, if things come out of the meeting which requires urgent or substantial change, what's the usual process for implementing these changes. So, an action plan is created and it's normally – dependent upon how the assistant chief constable desires it – it's either return in three months with the suggestion about how to proceed, or indeed on certain occasions it can be, come back in three months and demonstrate that you've changed it.

111. I am asked if I refer to Dr Stevenson for advice on written content only or is he referred to on how the training is done in practice, in terms of scenario training and practical training for officers. I consult with Dr Stevenson on both the written material and the practical skills within the programme.

112. I am asked what the process in place is for the review and approval of the First Aid material by Dr Stevenson. As we've been working with the programmes recently, there have been meetings where we have sought his advice and guidance. Prior to any changes being made, Dr Stevenson will receive the information he requires to assess and advise upon.

113. I am asked how the manuals or Lesson Notes are reviewed by Dr Stevenson, if he is sent a copy of the relevant chapters by email or the manual/Lesson note in its entirety. That would depend on the nature of the change. For full course amendments, or significant changes, it would be the case that he would receive the full manual for review. When it comes to

smaller content changes then relevant modules may only be reviewed. In either case this can be e-mailed or delivered as hard copies.

114. I am asked to confirm if Dr Stevenson is consulted in terms of every change to the contents of the lesson notes and if his approval is sought. I can confirm that we consult with Dr Stevenson when changes with the notes are planned. Approval will be sought, unless it is a small change which isn't changing any medical information or intervention.

115. I am asked how I liaise with Dr Stevenson to ensure consistency and standards are met. Aside from the quarterly clinical governance meetings we will liaise by e-mail, Microsoft Teams, or phone call as and when it is suggested by either party.

116. I am asked if I have had any input in the changes relating to Acute Behavioural Disturbance and Positional Asphyxia. No, aside from Richard Stevenson getting on board. He has a special interest in Acute Behavioral Disturbance. He's authored on Acute Behavioral Disturbance, so when we brought him on board to review all our programmes, that was an area that he really wanted to have a look at and indeed myself and Jim Young and a few others went to see him lecture on Acute Behavioral Disturbance at Glasgow Royal Infirmary, he would do things on Acute Behavioral Disturbance, to registrars for example, and we got invited along to that

117. I am asked where the training is now for both probationer and recertification when someone has identified as subject going through a mental health crisis. So, it doesn't. The training does not pick up mental health crisis. It does pick up on Acute Behavioural Disturbance, as you can imagine. When we talk on Acute Behavioural Disturbance, it's broken into three parts. What is it? So, medically, what do we anticipate it is? The signs and symptoms or expected signs and symptoms which might be presented, and then the suggested actions that could or should be looked at for taking. That's kind of

the same as all first aid, which focuses on that: what is it? What does it look like? What do you do?

118. I am asked are officers trained for example to call an ambulance in circumstances of emergency which include Acute Behavioural Disturbance and Positional Asphyxia and if so, are they trained on the information that should be provided to call handlers or paramedics. Both Acute Behavioural Disturbance and Positional Asphyxia are trained as medical emergencies, so calling for medical help is trained as part of those subjects. We have recently introduced a format for casualty handover but previouslywe've relied on ambulance control asking the appropriate questions and being guided by them for the information they require, but we've recently introduced a section within operational first aid which talks on the best information. Would you like me to give you it?

119. It follows an acronym, which is ATMIST, which is what the Ambulance Service use as a structure for them. So, it's the age of the person. Then, it's the time of the incident and the mechanisms of injury, which is just how something's happened. Injuries that are found. Signs and symptoms is the S, and then the T is any treatment that's been given, and that just allows a prompt handover, either over the phone or radio, or indeed face-to-face with ambulance staff.

120. I am asked how recent this training was implemented. Since March this year. I am also asked if this is currently part of Manual Unit 1. It’s going into that one which is being updated. It’s actually being printed now for the next probationer intake. It already is in refresher training.

121. I am asked what the reasoning was behind introducing it. Just more support for cops trying to help the Ambulance Service with their triaging. Basically, we were in a position where cops were feeling like Ambulance wasn't responding perhaps as well as they could, so we spoke to the

Signature of witness…… [redacted] …….

Ambulance Service and said, "What information do you need which could help the process?" And that's where that came from.

Training Material as of October 2022:

Unit 1 Operational First Aid Probationary Training Programme amended 20th May 2021

122. I am now shown Unit 1 Operational First Aid Probationary Training Programme PS18581 amended 20th May 2021 which was in force at October 2022 and is the current training program. I am referred to page 35 which outlines the lesson aims as follows:

"The Learner will be able to explain the risk factors associated with Positional Asphyxia".

And Learning outcomes as follows:

"The Learner can: -

I. Describe the risk factors that increase the risk of Positional Asphyxia

II. Describe the ongoing management of Positional Asphyxia."

123. I am asked to briefly outline what is covered in this section. We discuss the inherent risks of restraint and link relevant OST techniques to those risks. Recognisable signs and symptoms are explained and of critical importance is the ability of officers to manage that risk before positional asphyxia can occur. Should a person be unresponsive and not breathing then CPR is indicated.

124. I am asked, in my opinion, is the training on Positional Asphyxia adequate and fit for purpose. Yes, I do.

Signature of witness…… [redacted] ……

125. I am now shown page 39 of Unit 1 Operational First Aid Probationary Training Programme which is titled 'Unit 1: Lesson 8 Acute Behavioural Disturbance', which outlines the lesson aims as follows:

"The Learner will be able to recognise and manage a casualty who is suffering from Acute Behavioural Disturbance".

And Learning outcomes as follows:

"The Learner can: -

I. Summarise the recognition features of Acute Behavioural Disturbance

II. Describe the ongoing management of Acute Behavioural Disturbance".

126. I am asked to briefly outline what is covered in this section. We identify that ABD is a medical emergency, and a range of medical factors can be the cause. Due to this, officers are advised that an ambulance needs called asap, and the person needs managed as well as possible.

127. I am asked, in my opinion, is the training on Acute Behaviour Disturbance adequate and fit for purpose. Yes, I do.

128. I am also referred to page 41 which addresses the Management of Persons with Acute Behavioural Disturbance and says the following:

"It is recognised that controlling a person suffering from ABD will always be very difficult. Officers/staff may have to place the person face down on the ground in order to restrain and handcuff them safely. Whilst the risks of Positional Asphyxia affecting a person who are presenting symptoms of an ABD are far greater than for a normal violent person, sudden death as a result of cardiovascular collapse and extreme abnormal physiology is more likely.

Signature of witness…… [redacted] …….

Persons experiencing ABD must be examined at hospital - even if they suddenly calm down before they get there. They can collapse very suddenly and attempts to resuscitate are usually unsuccessful. Be mindful that: -

- *Once handcuffed, officers/staff should try not to hold the person face down.*
- *Immediately after the person comes under physical control, they should be placed onto their side or into a sitting, kneeling, or standing position. Prolonged restraint in the prone position must be avoided.*
- *Call for immediate emergency medical assistance and transfer to hospital.*
- *Observe the person's condition continually whilst being restrained, as cardiac arrest can occur suddenly, and develop beyond the point of viable resuscitation within seconds rather than minutes.*
- *If the casualty becomes unconscious and stops breathing normally, begin CPR.*

129. I am asked if this particular section is covered in probationary training and recertification as well. Yes, at probationer training and recertification. In Operational First Aid, we do everything practically, so we don't currently use a PowerPoint in the first aid input, for example, but we would expect that these factors are discussed. We stopped using PowerPoints in March.

130. I am asked what the reasoning behind the topics that were covered and how I decided what to include. So, there was really only one major adjustment, and that was the introduction of catastrophic bleeding into the programme. Everything else, I think, kept going, but we introduced something called "pressure bandages" into the programme, and we adjusted the primary survey away from this danger –response – airway - breathing. We changed I to bring catastrophic bleeding to the top of the tree, and that was in response to trauma risk out in the public.

131. I am asked what the process was for putting this program together. So, I wrote it, and then it goes through my line manager, normally a couple of times back and forth to make sure we're utilising all the techniques and skills,

Signature of witness…… [redacted] …….

and happy with terminologies, and then the final job will be to work with quality assurance, who then liaise with the SQA because everything that gets taught in probationer training falls under the 'certificate of policing'. So, if you adjust a programme, it needs to go to them to still agree that it's still at the same level, and it still hits the right number of points. So that the integrity of their entire programme is still secure. So that's how quality assurance will have got involved, and then Richard Stevenson obviously, kind of, gives us the clinical look to make sure he's happy with everything that's discussed.

132. I am asked if the person above me then signs off. Yes, Inspector Bradley signs off. From my understanding. That's as far as I see it go. He may then go up the tree for it.

133. I am asked if there are several meetings to discuss the contents of the programme. There have been plenty of meetings and discussions during this most recent change to the course. Previously to that, meetings took place, but not as frequently as currently.

134. I am asked if police officers are taught what to do when a person is unresponsive and not breathing during their probationary training. Yes, so if a person is unresponsive, and not breathing, the airway must be checked or opened. Breathing must be checked, and then the decision on what to do next is based on the absence of normal breathing or otherwise.

135. I am asked, what officers are taught when a person is unresponsive and not breathing, in particular when they should remove handcuffs or leg restraint when performing CPR. There was nothing in the manuals which suggested anything relating to restraints.

136. I am asked is there probationary training on restraint insofar as it relates to the application of weight to the subject during a restraint, the length of the restraint, or the use of a safety officer to monitor breathing of a subject.

Signature of witness…… [redacted] …….

The final one about safety officers, that's not one which I'm familiar with however, I've not taught OST for five years now. As regards length of restraint, it's as little as possible, and as soon as practical we'll train them to move them on to their side at least. Regarding the application of weight. Yes, so we talk about risk factors, the things that make it worse, and one of them is obviously keeping a subject down on the ground or in a position in which they can't escape. The application of weight over the torso is also likely to make breathing harder. So, when we do OST there's a lot of work on safe restraints, or about keeping weight off the torso and away onto the shoulders, for example, but the manual talks about principles of trying to keep weight off of people and restraint for the shortest time feasible.

Operational Safety and First Aid Training- National Recertification (2 Day Course) Course version 1.0 dated November 2020

137. I am shown PS18579 Operational First Aid Training- National Recertification 2 Day Course dated November 2020 which was in force as of October 2022. This document outlines the course and its delivery. I am asked if I was involved in producing this material. Only in terms of monitoring the delivery of the first aid aspect. For the 2020 version, I will have ensured that the programme is up to date with the current requirements. Back then, of course, I would have been answering up to a sergeant at that point. Which one it was at that point in time, I'm not too sure.

National Operational Safety Training: Teaching Pack National Recertification 2 Day last amended 06 October 2022.

138. I am referred to Position Statement 8 Training SBPI-00358 on behalf of the Chief Constable of Police Scotland which discusses PS18569 National Operational Safety Training: Teaching Pack National Recertification 2 Day last amended 06 October 2022 at paragraph 88, 89 and 90:

"At page 21, the timetable outlines that on day 1 there will be a facilitated discussion and relevant PowerPoint slides used to teach students how to identify risk factors and signs and symptoms of a Positional Asphyxia. 125-145 minutes is the time listed. During the course, various techniques are reviewed and taught.

Appendix B lists techniques and assessment marking criteria for the instructors. All the criteria must be met for a student to be deemed competent in a technique. Under Side Ground Control and Ground pins, the student must be able to recognise the dangers of positional asphyxia. The Side Ground Control also adds that the officer should be positioned to the side of the subject.

Under the scenarios with debrief considerations (p 74), listed in the debrief considerations is "identification of positional asphyxia and acute behavioural disorder if applicable" and recognition of ABD, positional asphyxia."

139. In reference to the above paragraph, I am asked if I was involved in producing this teaching pack for probationers/recertification. This teaching pack was produced by the Officer Safety Training Team; however, my input would have been the lesson plan associated only with the Operational First Aid section of the programme.

140. I am asked what the reasoning was for including the sections outlined in the position statement, specifically on page 21 which covers Positional Asphyxia and Acute Behavioural Disturbance. As these subjects are of vital importance given the medical emergency status of both, it was pertinent to train both conditions/occurrences. It should be noted that both Positional Asphyxia and ABD have been incorporated in Officer Safety Training for as long as I have been involved in this training, which was 2004.

Signature of witness…… [redacted] …….

141. I am referred to page 21 of the Teaching Pack which references the provision of PowerPoints slides used to teach students about Positional Asphyxia and Acute Behavioural Disturbance. The student activity section of this lesson outlines that students were able “watch, listen, question and answer”. I am asked if videos were used to teach students on these two conditions. We had no videos relating to Positional Asphyxia in the programme. For Acute Behavioural Disturbance, we used a short video footage in which real life example of Acute Behavioural Disturbance could be observed and discussed.

142. I am asked what the reasoning was for including teaching on Alcohol Intoxication and Drug Intoxication. As I recall, the decision for inclusion was to ensure that we were giving officers the appropriate training on identifying potential intoxication and the most appropriate management of same.

143. I am asked what the process was for putting this Teaching Pack together. As it was the Officer Safety Training team that put the teaching pack together, I’m not in a position to comment on the full process, other than to say that the lesson plan I put together for the Operational First Aid section will have been incorporated into the full pack.

144. I am asked what support I received in creating this programme and if Dr Stevenson was involved in developing this teaching pack. The programme was developed with support of Dr Stevenson when putting the lesson notes together. This was to ensure accuracy of information and techniques and have his clinical guidance on all aspects of the course. He was also presented with the lesson plan, but I’m unsure to what level of involvement he had in the development of the teaching pack.

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Operational First Aid PowerPoint version 2.0

145. I am shown PS18585 Operational First Aid version 2.0 which was in force as of October 2022. I am asked if I was involved in creation of this document which was used for the National Recertification 2 Day Course training course. Yes. Althoughthis isn't currently getting used. So, it will still exist because there was nothing wrong with it, so I've not deleted this in any way, but I've chosen to have the delivery to be entirely practical and without the need for a PowerPoint.

146. I am asked why the decision was made to remove PowerPoints. It was simply down to how I looked at how the programme could run, and if a PowerPoint is used, it doesn't support the learners, it supports the trainers. That's my opinion, because the trainers are effectively getting drawn towards the board, and they're talking about theories of practice, when in actual fact, for the practical skills, they don't need things pointed at them. So, it was my belief that on the floor training, with all the theories and principles coming up whilst they're actually in practice, was a far more appropriate way to deliver the programme. I thought there was too much time spent inactive as a learner. Too much time spent talking about theories, and not being on the floor actually practicing the things which are already getting discussed anyway. I just thought it was wasted time. All the same material, aside from some videos-- We still give them the opportunity to show videos, because the videos are worthy.

147. I am asked what kind of videos are now included. So, some of the ones that are actually within this have been drawn across, and it's down to the trainers to decide if they wish to show them. So, bleeding ones, quite often people would quite like to show the bleeding ones because that's our biggest change in the programme is catastrophic bleeding. So sometimes, to give a full appreciation, they'll maybe show those.

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148. I am asked if the new programme covers Positional Asphyxia and Acute Behavioural Disturbance in so far as it relates to symptoms of someone from an ethnic minority background. No, it doesn't go into it.

149. I am asked if there is anything else I'd like to add about the new Operational First Aid programme. I'm proud of where it sits just now, I think. Where it is now is far closer to where it should be in my belief.

150. I am asked to clarify what I mean by where is should be and where do I think it should be. It's the basics done well, which is a term that Dr Stevenson uses, which is just "the basics done well." That's all the NHS want, basics done well. So, we've got the basics trained really well, and we've got our, sort of, higher profile techniques are now in there as well, all the major trauma stuff. We're slightly ahead of some of the English and Welsh forces with regards to some of these things. So, we're actually, yes, we're very pleased, very proud of the fact that we've moved the programme on so significantly. Time will tell if we've got it right, and it will undoubtedly need reviewed. It would be wrong not to consider that it will be reviewed in time, as all programmes should be.

151. I am asked if there are any lesson learned from other jurisdiction that has assisted in the development of the new programme. Yes, I sit on the National First Aid Forum, and that's all the forces from England, Wales, BTP, Civil Nuclear (being a police force), PSNI, who are represented at that forum, and it's just general discussions about the sort of things that people are involved in, any changes to programmes, any particular instances. So, a really high-profile one for us would be Naloxone, and how we'd gone ahead and got Naloxone into the programme. England and Wales are, apart from a few forces, everyone else is really interested. So, the sort of work that we've got on that, we can then push out to other forces to see if they might wish to proceed. So that's an example of how the forum can work. So, every so

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often, yes, we'll get something pops up which we could potentially look at implementing, or at least keep it as a point of note.

152. I am asked, in my opinion, is the new programme adequate and fit for purpose. I believe it is, yes.

Operational First Aid Programme as of September 2023

153. I am asked if there have been any recent changes to Operational First Aid. Yes, there has been changes, as we have a new programme. There has been, really only in regard to trauma, to bleeding and injuries, but it's quite a large section now because we've introduced quite a lot of equipment into cars, tourniquets, and such like. So, we need to train for the kits which are available now.

154. I am asked where training is at present day. So, the programme has been getting delivered from March 2023, it is the new Unit 1 Operational First Aid Programme. The newer trauma techniques were introduced earlier than March as it allowed us to evaluate the teaching and new equipment. Nothing got removed from the programme, it was just the addition of a few extra techniques that went in, and a change in philosophy of teaching, primarily. So, the manual now, the one that gets produced for probationer training, has a far larger section which now talks on use of tourniquet, how to pack wounds, use of chest seals for somebody who might well have been stabbed, and a whole load of extra equipment which is now getting utilised in the courses.

155. I am asked what the process was for introduction of the current changes. So, they've been discussed at clinical governance for, probably, a couple of years to get to where we are just now. It was on the back of those inquiries, the Manchester one being the big one, which came out and said, "Police services know these incidents happen, so they should be trained and equipped appropriately." So that was one of the drivers for getting the updated programme through our Clinical Governance Group.

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156. I am asked if the learning outcomes have developed, or new ones introduced. There's only one new learning outcome, and that's the one on casualty handover, and that's the ATMIST one I told you about earlier on. Every other learning outcome is still the same. There have been a few changes, like the introduction of trauma techniques and a wee word here or there, but the rest of it's the largely the same.

157. I am asked if officers are now taught what to do when a person is unresponsive and not breathing, when it comes to removing handcuffs and leg restraints when performing CPR. From the new manual onwards, it's now included. It's a very short statement which reminds officers that the most appropriate way to deliver CPR is with handcuffs removed.

158. I am asked if there are any substantial changes to Positional Asphyxia and Acute Behavioral Disturbance in the 2023 programme. None at all.

159. I am asked if the new programme is used to train both probationers and recertification. Yes, it does. It's always played out that way. Since a couple of years ago when we lost the Moodle package, the two programmes are the same. It's just the time period which differs. It's just a wee bit different, there's more time associated with probationer training because, in theory, we work with them as if they've never seen anything first aid related.

160. I am asked if there is a Checklist of Topics to cover similar to that of Officer Safety Training within the new programme. Yes, there has been. The lesson plan directs the trainers on structuring the teach to accommodate all sections as well. There is a new assessment checklist coming into it as we're intending on moving to this formative assessment style in the very near future. That will look very similar to the OST checklist, so that will play out quite similarly.

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161. I am asked to outline what the assessment looks like for the new programme. The assessment at Tulliallan is similar to that contained within PS18579 Operational Safety and First Aid Training- National Recertification (2 Day Course) Course version 1.0 dated November 2020. However, it does differ in terms of how it is administered. The only variation on it is, for probationer training, we require every single one of these topics to be assessed. So, they're asked one question on each topic. For recertification training, it's only two topics, randomly selected by the assessor. So, it's an agreed assessment between the instructors before they go in, right, "What two topics are we going to cover for knowledge checks?"

162. I am asked what happens if someone fails their assessment. There's a period of retraining or just, sometimes, if somebody doesn't pass a certain thing, normally it's just off to one side, and just a brief moment of retraining, and then they go back through a second assessment.

Contact with other Witnesses

163. I am asked if I have had contact with other witnesses in this Inquiry. Yes, I have spoken to Jim Young. I've spoken to David Agnew, Richard Stevenson, and ended up with a conversation two days ago with a fellow called Stuart Ord. Because he got in touch and said, "Given a nod at quite short notice," so he was trying to refresh his memory on things from his time.

164. I am asked in what capacity did I speak with these other witnesses. Well, certainly with Jim. Jim and I worked together at the college post-incident, and then we obviously worked in the same, sort of, department around about the same time when we were making these adjustments. For Stuart Ord, he was my second line manager at Tulliallan, but he wasn't in that role for very long, so he was just trying to get his memory refreshed about how we were training at that point. Spoke to David last week because he came in for his interview recently with the Inquiry. That was just to satisfy my own curiosity and relax me more than anything else. And Richard, I spoke to

him just on a personal note because he was a bit, kind of, querying, well, he never got involved until 2017, so why might they wish to speak to him given that the incident predated his involvement as clinical advisor with Police Scotland. I said I don't know, but I can imagine there'll be a history looking at.

Post Involvement and Media

165. I am asked if I have been involved with investigation since 03 May 2015. No.

166. I am asked if I have been following the inquiry via the news or social media. Yes. It's only of recent, actually, since yourselves had got in touch. I started watching some of the evidence. Some of the medical evidence, for example. Jim's evidence, I watched that. I'm working my way through it.

167. 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 November 3, 2023 | 11:17 AM GMT

Signature of witness…… [redacted] ……

Signature of witness……  …….