AM & FC Notes on AP consultation with Martin Graves, OST expert 28th June 2019, Crown Office, Edinburgh

[redacted]

[redacted]. Training environment never the same as in the field?

MG- agreed. Difficulty in getting people to understand that one side might be applying the rules and the other side is not. This case interesting medical evidence. In the last 8 – 10 years more understanding (in police training) re medical issues. You have to do something, not always to the benefit of the individual concerned, but meets the needs of society/ public opinion. Someone needs to understand medical evidence.

[redacted]

AP – in report you refer to optimum number of cops in a take-down situation as five officers?

MG – Yes – 2 in a takedown is extremely difficult. You want additional officers to take up different position. It wasn't just police – also prisons, mental health

institutions multiple approach is the safest way – limits time and degree of force so 5 would be optimum.

AP – and the ground acts as a stable position?

MG – Yes If you sleep on soft mattress, can do so all night, but on hard surface with weight on top – so have to limit the time that force/weight applied

[redacted]

MG – Described a case in which he was called in as a third expert and spoke to family to explain his independence and how he had worked for both sides in the past. I'm independent but been attacked in court over this. Duty bound to raise concerns if I see them. Trying to prevent it happening again (probably won't) trying to have less stress for all concerned.

AP – [redacted]. Is their first duty to get there and gather as much info as possible on the way?

MG – Yes, that's best practice. You hope Control are getting more information and clarifying. It's very rare that you are aware of everything available on arrival at scene. Info that they get later might have altered their approach. What's important is what they knew. They were dealing with a risk to themselves and the public.

[redacted]

MG – Timeline very quick. Officers making decisions in quick time. Hindsight is a brilliant thing. The officer who should be criticised is the one who cannot explain the process they went through. It falls to others to second guess what happened. Some officers don't have the capacity to articulate (their thought processes). In this case they made the decision to approach in a certain way – 'hard stop'. I can't criticise. I've done it myself. They had to stop the individual. Stop them doing anything. Reacting. This developed very quickly, it changed very quickly. Officers lose control of the situation, lose control of Mr Bayoh. Officers coming in responding to the situation they see but not in possession of knowledge of what occurred before they arrived (and put 2 +2 together and come up with a theory)

It can be hard to explain to people how police officers think. They think in a certain way, otherwise they get injured or public do. Have to bear in mind their perspective. I try to get people to think the way officers think and how they have applied their skills.

AP – [redacted]
Not seen in possession of knife – is it reasonable for officers to assume he still had it.

MG –yes, a very sensible conclusion. The thought process would be to secure him. Even if he did not still have knife, he could have gone to grab it from where he had dropped it. That's the worst case scenario – so for police – have to secure individual. Doesn't change what they did – most sensible thing for the scenario.

[redacted]

MG – Yes, and also relevant - Officers' perception that it could be a terrorist related, which might have steered them away from thinking about drugs/ ABD. In my experience in this line of work I notice that police either consider or discount or don't recognise ABD. Are these things a priority when you are dealing with terrorists with a knife? Not at forefront of the minds of some officers, they are dealing with a terrorist with a knife.

In some cases, not this one so much, when the dust settles , they don't think about it and it's too little too late. In this case there was little option but to engage.

AP – [redacted] suggest they (police) could have stood back and contained him?

MG – When ABD came to fore in London 1990s – case I was involved in – IPC thought process was to constrain rather than restrain. That's great if you can control/ shadow person – 'floating bubbles'. MG gave example of girl with ABD running away into traffic on M6 while police stood back – "damned if you do, damned if you don't."

Could they have waited? Yes, but if he had a knife and attacked first two, then the next officers on scene would have had more to deal with.

AP – unreasonable to move in?

MG – No. As an officer you would have confidence in your own and colleagues' abilities. One cop was a big lad who probably thought in fight they would probably win eventually. So I think that option to go in quick and deal with it it was the best option, not an unreasonable option.

AP – Other options? [redacted]

MG – To do harm the knife has to be in striking distance. However, if distance is being closed down, not enough. Reaction is always slower than action. So sometimes better to close in to stop him accessing the weapon, more chance of stopping the action. Here they (police) were being closed down.

[redacted]

AP – RE sprays – not rely on it as the only option? [redacted].

MG – not uncommon for it not to work. Have seen people smile and not react– and can take up to 20 seconds to work. Question of whether you missed the target. Depend on mental capacity and medical?

Used to be one in ten not affected by sprays but now number growing and anecdotally hearing that almost 20% not effective.

AP – [redacted]. Was the fact that it was deployed at all significant?

MG – it's a lesser use of force because of injury, but benefits - gives cops better control if it works. They did not go straight in and batter him. Tried to give themselves tactical advantage. As a use of force it's a lesser use of force than a baton strike, punch or kick as less risk of injury. Also indicative of tactical options. Police trainers try to teach cops to use different options – try to think what's available to you. In this case they used just about everything in the catalogue to control the subject

[redacted].

AP – Time of restrain excessive?

MG – No, not excessive with the level of resistance and strength and fatigue setting in. Analogy with sitting in chair resisting only – no fighting – would still take time – until you or I get tired. I've seen these types of restraint five or six officers – 8, 9, 10 minutes before under control. Also seen much quicker, but also much longer. Time not excessive at all.

AP – Monitoring on ground?

MG – Monitoring cannot take place until the person under control – The 'big breath moment' – change from control to monitoring. Think about what you're dealing with. Might be looking after the individual or looking for the knife. Thought process re positional asphyxia should be kicking in – handcuffed and have been lying on top of him. Is he alright?

I've some issue with the Sgt (Smith?) – OST trainer – considered and ruled out ABD – I disagreed with him. He should know better. He should have been aware of it and asking the questions. He was coming in at a later part of restraint.

Some of that might be down to the training materials of PSOS – I was rewriting the manual in 2012 in England but now been taken on board by PSOS.

Training materials – defects I picked up on – re positional asphyxia – doesn't need to be on ground. So, can be in position in a van. It's all to do with body's need for oxygen. I thought training was lacking in telling them to put him into a position where he got enough oxygen. So, if in a fight, then restrained, this is what you do after that – at the big breath moment. Who is looking after them? What care are they getting? It's about getting officers to click into this thought process.

AP – Action of police once restrained. You are critical of lack of recognition of the signs of ABD – time and action taken at this point?

MG – Difficult to answer but glaring pieces of information that should have added to the mix. Relevant factors –

- Strength
- Lack of response to sprays
- Not responding to commands

If you did consider it? If not why not? (That would have come out with a good PIM process). I could not see anything in the materials to show me that they had considered ABD. Glaring factors. I did not know if that have altered outcome medically.

AP – so to recap – you are not critical of the police re their approach, taking him down, the restraint in itself, but you are critical of the lack of recognition of signs of ABD?

MG – Could they have done other things? Yes, what they did do was reasonable

AP – Bystander perception?

MG – Confirmed this was very common. 'Clapham omnibus' – People see a snapshot but not what's gone on before. Those watching don't know what has happened beforehand. Indicative of all these situations where people resist. Necessary. Looks over the top but it's the safest way for the officers and individual. Example given of person in prison refusing to come out of cell – team of 5 sent in. Reduces risk of injury to officers and individual.

Also cited an example with a mobile phone footage recording without knowing full story – and body cameras worn by police gives good view. So very common for public or sometimes even other officers to say it looked over the top.

[redacted]

MG – important to remember that many injuries such as abrasions caused by contact with the ground and not blows.

AP – Page 31 para i – (referring to realisations that baton strikes not effective).

MG – Police officer realised it did not work and jumped on him to take him to the floor.

[redacted]

MG – officers can get caught up in a circle of action – repeated baton strikes. One officer here using one option which did not work, then bringing him to the ground.

AP – All in the public gaze? [redacted]

MG – Body cameras are good – see officer view and protects officers and subjects.

AP – Point he deteriorates ?

MG - ambulance could have been called earlier, tho' do not know if it would have made a difference. Described footage used in training of an American arrest and restraint. Point is to try to get cops to call for medical attention earlier. When you identify someone might be suffering from ABD – get them to hospital not police station. It's a frightening thing to see suddenly someone who has been fighting with 5 cops go silent and stop.

[redacted]

MG – They were dealing with a difficult individual. Taser might have helped in this situation. Equipment and training are constantly under review.

[redacted].

MG – I could list cases where officers have provided different accounts from each other. It can be refreshing when someone says they cannot remember, as they only concentrating on holding one limb. Traumatic events do have an effect. Best way to deal with that – post incident procedures – works very well. What I could not establish – these standard protocols don't seem to have been followed. I would have triggered these protocols immediately and obtained first accounts from these officers. That causes issues. If they provide accounts it allows people in power to assess reasonableness. To some degree (fact they did not) hampered investigation. Causes more problems than it resolves in long run. Cites the officers being put together in the tearoom – if that happened it should have been monitored and controlled. Public perception of officers getting their stories straight.

AP – Once the officers had control they ought to have taken account of what happened?

MG – haven't clicked into the ABD side of it. Critical bit – once they got him under control they should have considered positional asphyxia and warning signs of ABD. They are clicking into first aid mode.

AP – Were they taking too long to get help?
MG – don' think it would have (made a difference?). Might have got an ambulance quicker. They did first aid. Risk factors for ABD – if Sgt (Smith) considered them they were there.

AP – was there a failure to appreciate the risk quickly enough?

MG- Yes, with caveat – training materials – degree of emphasis. Positional asphyxia in first aid manual but not in the OST manual. It was still referred to in manual as excited delirium rather than ABD. We (England) changed years earlier. PSOS now adopting training.

Two issues I raised were training and the Post incident management. Minor issue of an officer not having his baton with him – but perhaps hypercritical. It was a difficult situation for everyone. If a Taser had been available there might have been a chance to take him out. There were not a lot of options available. I think they did the best they could in the circumstances.

AP – Re stamping?

MG – It's about the perception of the officers. Rely on what the officer has seen. Different accounts of what went on. Sure he had some interaction with the her (PC Short) – that's how she ended up on the ground.

[redacted]

MG – Level of risk is high – knife. If stamped on, all you are doing is adding more, another example. If perception at time, that's their perception. If he's wrong, it's still his perception.

AP – So, the finer detail of his interaction does not necessarily impact on the initial decision to detain him?

MG – agreed.