ipcc
independent
police complaints
commission

Mr Andrew Hall

Independent investigation into the interaction between West Yorkshire Police and Mr Andrew Hall prior to his death on 13 September 2016

Please note, this investigation was completed and submitted to the decision maker before 8 January 2018, while we were still the IPCC. Therefore, the report will contain the investigator's opinion, which may differ from the final outcome. Any difference of opinion will be recorded in footnotes throughout the report. The report refers to the IPCC and the Commission throughout, and does not reflect the new structure of the IOPC.

Independent investigation report

Introduction

The purpose of this report

1. The IPCC appointed me to carry out an independent investigation into the interaction between West Yorkshire Police (WYP) and Mr Andrew Stephen Hall prior to his death on 13 September 2016. Police officers from WYP arrested Mr Hall at Huddersfield Royal Infirmary (HRI) at 7.20am on 13 September 2016, and transported him to the custody suite at Huddersfield police station. During his time there, a number of police officers and detention staff restrained him. A custody nurse examined Mr Hall before paramedics returned him to HRI by ambulance at 10.50am. Mr Hall was pronounced deceased at the hospital at 12.45pm on 13 September 2016. This came to the attention of the IPCC on 13 September 2016 as a death or serious injury (DSI) referral. The case type changed to a conduct investigation on 18 October 2016, as I believed there was an indication that five officers may have behaved in a manner that would justify the bringing of disciplinary proceedings.

2. This is my report for the Commission. It summarises and evaluates the evidence, and refers to relevant documents. In my conclusions I will:
    a) set out the facts that have been established, the sequence of events and their consequences.
    b) give my opinion about whether the subjects of the investigation have a case to answer for misconduct or gross misconduct, or no case to answer.
    c) draw attention to any evidence which may be the basis for a decision by the Commission delegate that performance of any subject of the investigation may have fallen below the standard expected of them.
    d) draw attention to any lessons which may need to be learned by any organisation related to the investigation about which the Commission delegate may wish to make a recommendation.
    e) provide the Commission with sufficient information, and if appropriate express a view about whether it should refer any subject of the investigation to the Crown Prosecution Service (CPS).

3. Commission delegate A as the Commission delegate, for the purposes of this report, will exercise the powers and obligations of the Commission.

4. I will send this report to WYP, which must then advise the Commission delegate what action it will take in response to it. If the Commission delegate does not agree with WYP, he may make recommendations and ultimately directions about what action to take. The Commission delegate will also decide whether to make a referral to the CPS.

5. This investigation is also intended to assist in fulfilling the state's investigative obligation arising under the European Convention on Human Rights (ECHR) by ensuring as far as possible that the investigation is independent, effective, open

and prompt, and that the full facts are brought to light and any lessons are learned.

6. Article 2 of the ECHR imposes an obligation on the state to protect human life. This involves both a prohibition on the state taking life and, in certain circumstances, a positive duty to protect life.

7. It was determined at the outset of the investigation that the circumstances of Mr Hall's death potentially engages Article 2 because he was in police custody when his condition deteriorated in the period immediately prior to his death; and because there was an indication that the actions of police officers may have caused or contributed to his death.

Other investigations

8. The Calderdale and Huddersfield NHS Foundation Trust commenced an investigation to understand Mr Hall's medical history, his medical treatment on 13 September 2016, and his capacity during his first Accident and Emergency (A&E) admission at 2.05am on 13 September. The NHS investigation will also review the appropriateness of the decision to discharge Mr Hall into police custody. This investigation is still ongoing at the time I wrote this report.

The investigation

Terms of reference

9. Commissioner A approved the terms of reference for this investigation on 4 October 2016. The terms of reference specific to this investigation are:

    1. To investigate the interaction between WYP and Mr Hall prior to his death on 13 September 2016. In particular:
        a) The decision to arrest Mr Hall and transport him from Huddersfield Royal Infirmary to the custody suite at Huddersfield police station.
        b) The use of force by officers at the custody suite during the detention of Mr Hall.
        c) The actions taken to obtain medical assistance for Mr Hall at the custody suite.
        d) The manner in which family members were informed of the death of Mr Hall.
    2. To assist in fulfilling the state's investigative obligation arising under the ECHR by ensuring as far as possible that the investigation is independent, effective, open and prompt, and that the full facts are brought to light and any lessons are learned.
    3. To identify whether any subject of the investigation may have committed a criminal offence and, if appropriate, make early contact with the Director of Public Prosecutions (DPP). On receipt of the final report, the Commission shall determine whether the report should be sent to the DPP.

4. To consider and report on whether there is organisational learning, including:

   - whether any change in policy or practice would help to prevent a recurrence of the event, incident or conduct investigated;
   - whether the incident highlights any good practice that should be shared.

Family concerns and complaints

10. I met with Mr Hall's family and they raised a number of questions they wished to see addressed during the IPCC investigation. The terms of reference encompassed these concerns, notably: the manner in which family members were informed of Mr Hall's death, and the purpose and duration of Mr Hall's partner's time at Huddersfield police station on 13 September 2016.

Post Incident Procedure and police officer identity protection

11. A police force often initiates a post incident procedure (PIP) following instances when police officers have been involved in an incident where a person has died. The police force nominate a post incident manager (PIM) and they facilitate, manage and ensure the integrity of the PIP. They facilitate the early stages of the investigation of the incident and take responsibility for the welfare of the officers involved. In such a procedure, the IPCC will attend and recover the first accounts of the officers involved.

12. At a PIP, a police force can provide its officers with identity protection by using pseudonyms, however, the IPCC will be provided with a list of the officers' names. For the purposes of this independent IPCC investigation report, I have referred to the officers by their pseudonyms.

Subjects of the investigation

13. The appropriate authority re-referred this investigation to the IPCC because in my opinion there was an indication that the police officers listed below may have:

    (a) committed a criminal offence, or

    (b) behaved in a manner which would justify the bringing of disciplinary proceedings

14. Any police officer or member of police staff whose conduct is under investigation is categorised as a subject of the investigation. A notice of investigation must be served on all subjects, informing them of the allegations against them.

15. They must also be informed of the severity of the allegations. In other words whether if proven they would amount to misconduct or gross misconduct.

16. I categorised the following people as subjects of this investigation:

Officer C

17. Officer C was a custody officer working at Huddersfield police station. On 25 November 2016, an IPCC investigator served them with a Regulation 16 notice of investigation under the Police (Complaints and Misconduct) Regulations 2012. The notice set out the conduct which was the subject of the investigation, that Officer C:

    - *acted as part of a group of officers who were involved in a restraint of Mr Hall and used a level of force which may have been unjustified in the circumstances. You appear to strike the right arm of Mr Hall at least five times during the corridor incident.*

18. I considered Officer C may have behaved in a manner which could justify the instigation of disciplinary proceedings. My severity assessment was that, if proven or admitted, the breach of standards of professional behaviour could amount to gross misconduct. I also considered that this breach could be construed as a criminal offence, in that Officer C may have assaulted Mr Hall.

19. Officer C attended a criminal and misconduct interview at the IPCC office in Wakefield on 14 March 2017. Officer C provided a prepared statement, and during the interview answered all the questions I put to them.

Officer D

20. Officer D was a Police Constable (PC) working as a gaoler on 13 September 2016. On 25 November 2016, an IPCC investigator served Officer D with a Regulation 16 notice of investigation. The notice set out the conduct which was the subject of the investigation, that Officer D:

    - *acted as part of a group of officers who were involved in a restraint of Mr Hall and used a level of force which may have been unjustified in the circumstances. You can be seen striking Mr Hall at least five times to what appears to be his head whilst Mr Hall was on his feet. You then appear to strike Mr Hall at least three times to the head whilst Mr Hall is in a prone position.*

21. I considered Officer D may have behaved in a manner which could justify the instigation of disciplinary proceedings. My severity assessment was that, if proven or admitted, the breach of standards of professional behaviour could amount to gross misconduct. I also considered that this breach could be construed as a criminal offence, in that Officer D may have assaulted Mr Hall.

22. Officer D attended a criminal and misconduct interview at the IPCC office in Wakefield on 15 March 2017. Officer D provided a prepared statement, and during the interview answered all the questions I put to them.

Officer E

23. Officer E was a detention officer (DO) working at Huddersfield police station on 13 September 2016. On 25 November 2016, an IPCC investigator served

Officer E with a Regulation 16 notice of investigation. The notice set out the conduct which was the subject of the investigation, that Officer E:

- *acted as part of a group of officers who were involved in a restraint of Mr Hall and used a level of force which may have been unjustified in the circumstances. You appear to strike the right arm of Mr Hall at least ten times during the corridor incident. You appear to kick Mr Hall during the corridor incident.*

24. I considered Officer E may have behaved in a manner which could justify the instigation of disciplinary proceedings. My severity assessment was that, if proven or admitted, the breach of standards of professional behaviour could amount to gross misconduct. I also considered that this breach could be construed as a criminal offence, in that Officer E may have assaulted Mr Hall.

25. Officer E provided a written response, dated 30 November 2016, to the notice of investigation.

26. Officer E attended a criminal and misconduct interview at the IPCC office in Wakefield on 23 February 2017. During the interview, Officer E answered all the questions I put to them.

Officer G

27. Officer G was a custody inspector working at Huddersfield police station on 13 September 2016. On 25 November 2016, an IPCC investigator served Officer G with a Regulation 16 notice of investigation. The notice set out the conduct which was the subject of the investigation, that Officer G:

- *acted as part of a group of officers who were involved in a restraint of Mr Hall and used a level of force which may have been unjustified in the circumstances. You appear to use your right knee to strike Mr Hall three times during the corridor incident.*

28. I considered Officer G may have behaved in a manner which could justify the instigation of disciplinary proceedings. My severity assessment was that, if proven or admitted, the breach of standards of professional behaviour could amount to gross misconduct. I also considered that this breach could be construed as a criminal offence, in that Officer G may have assaulted Mr Hall.

29. Officer G attended a criminal and misconduct interview at the IPCC office in Wakefield on 16 March 2017. Officer G provided a prepared statement, and during the interview answered all the questions I put to them.

Officer K

30. Officer K was a PC working from Huddersfield police station on 13 September 2016. On 25 November 2016, an IPCC investigator served Officer K with a Regulation 16 notice of investigation. The notice set out the conduct which was the subject of the investigation, that Officer K:

- *acted as part of a group of officers who were involved in a restraint of Mr Hall and used a level of force which may have been unjustified in the*

circumstances. You have identified that you struck Mr Hall to the head area whilst he was being transported by Ambulance to Huddersfield Royal Infirmary. It is believed that Mr Hall had his arms and legs restrained at this time.

31. I considered Officer K may have behaved in a manner which could justify the instigation of disciplinary proceedings. My severity assessment was that, if proven or admitted, the breach of standards of professional behaviour could amount to gross misconduct. I also considered that this breach could be construed as a criminal offence, in that Officer K may have assaulted Mr Hall.

32. Officer K attended a criminal and misconduct interview at the IPCC office in Wakefield on 13 March 2017. Officer K provided a prepared statement, and during the interview answered all the questions I put to them.

Policies, procedures and legislation considered

33. I examined a number of national and local policies in relation to this incident, in order to ascertain whether the policies were complied with, and whether the existing policies were sufficient in these circumstances.

34. These national and local policies were considered as part of a subject matter expert (SME) review.

Subject Matter Expert review

35. The IPCC commissioned a SME to review the actions and tactics of WYP officers and staff in relation to the use of force during Mr Hall's detention. Officer S of the Metropolitan Police Service (MPS) conducted this review, with reference to the College of Policing Authorised Professional Practise (APP) for use of force and detention and custody.

36. Officer S is employed within the MPS Officer Safety Unit, which is concerned with the development of Officer Safety policy and training. They are Secretary to the National Police Chiefs' Council (NPCC) Self Defence Arrest and Restraint Practitioner's Group, which is responsible for national Officer/Personal Safety Training policy and guidance. They were previously responsible for managing Personal Safety Training instructors and delivering training across the MPS. They have previous experience as a SME in relation to police use of force.

37. The College of Policing identified Officer S to me, following my request for a SME who was suitably independent of WYP and sufficiently qualified to review this matter on the instruction of the IPCC.

38. Officer S prepared two statements, which have informed my investigation.

Police use of force

39. Police officers are authorised to use force through a number of legal provisions.

40. The Police And Criminal Evidence Act (PACE) 1984, Part XI, section 117, relates to the power of a police constable and states:

'The officer may use reasonable force, if necessary, in the exercise of the power.'

41. The police Standards of Professional Behaviour states:

'Police officers only use force to the extent that it is necessary, proportionate and reasonable in the circumstances.'

42. A principle of Common Law states:

'It is both good law and good sense that a man who is attacked may defend himself. It is both good law and good sense that he may do, but only do, what is reasonably necessary.'

43. Police officers are only authorised to use force to achieve a lawful objective, such as acting in self-defence or protecting others. All force used must be reasonable and proportionate in the circumstances. There are different tests for determining whether force used was reasonable in criminal law and civil law. In criminal law, the question of whether force used is reasonable is judged in reference to the circumstances as the person using the force genuinely believed them to be. Even if that person is mistaken, they may rely on self-defence if the force they used was no more than would have been necessary if the circumstances had been as they perceived them.

44. In civil law, any mistaken belief as to the circumstances must not only be genuine, but reasonable. If their mistaken belief was unreasonable on the information available to them, they cannot rely on self-defence. The civil test is the appropriate test for the purposes of assessing whether there may have been a potential breach of the standards of professional behaviour. The criminal test is relevant when assessing whether there is an indication that any person may have committed a criminal offence.

The National Decision Model

45. The National Decision Model (NDM) is a risk assessment process that assists police officers making decisions by giving a framework of considerations to guide decision-making. The police Code of Ethics sits at the centre of the framework and all decisions should be made in accordance with this.

46. The five considerations are: gather information and intelligence; assess the threat and risk and develop a working strategy; consider powers and policy; identify options and contingencies; take action and review what happened.

47. A decision maker should follow the considerations in a circular manner, ensuring the decision making process is accompanied by continuous review.

Summary and analysis of the evidence

48. During this investigation, I gathered a volume of material. After thorough analysis of all the material, I have selected the evidence that answers the terms of reference for my investigation. As such, I have not referred to all the material gathered in the investigation in this report.

49. In order to reach my findings it was necessary for me to analyse and evaluate the evidence.

50. The standard of proof for a conduct investigation is whether there is sufficient evidence upon which a reasonable tribunal, properly directed, could find that a subject breached the applicable standards. For police officers those are the police Standards of Professional Behaviour (as set out in Schedule 2 of the Police (Conduct) Regulations 2012). Whilst the standard of proof for police staff members is the same as for police officers, the applicable behavioural standards are contained in the WYP Code of Conduct for Police Staff.

51. I have applied this as the standard of proof when considering the allegations against each subject, and in weighing the evidence in relation to each allegation. The reader should assume that every opinion, finding and conclusion expressed in this report arises from the application of this test.

52. I am required to form an opinion about whether there is a case to answer for misconduct or gross misconduct for each subject. In doing so I will not reach findings of fact that would be conclusive of misconduct or gross misconduct– these findings should be left for any subsequent misconduct hearing or meeting.

Chronology of events

53. Mr Andrew Hall lived in the Dalton area of Huddersfield with his partner.

54. Mr Hall's partner provided a statement to HM Senior Coroner in which they stated that Mr Hall took an amount of medication on the evening of 12 September 2016, due to joint pain and an inability to sleep. They explained that he *'took a couple of co-codamol and 14 (a strip) of Amitriptyline 25mg tablets.'* He also drank an amount of brandy. Later that night they found Mr Hall to be struggling to breathe and *'biting down on his tongue.'* A family member requested an ambulance to attend their address.

55. Mr Hall arrived at HRI at approximately 2.05am on 13 September 2016, and received treatment throughout the night.

56. At approximately 7.00am, hospital staff telephoned the police and reported that Mr Hall had assaulted a nurse. At 7.20am, police officers arrested him for common assault.

57. Officers transported Mr Hall to Huddersfield police station custody suite, arriving at 7.30am. Officer C authorised his detention in custody at 8.50am.

58. At 10.04am, officers escorted Mr Hall to the nurse's room in the custody suite. Whilst being returned to his cell, a number of police officers and detention staff

restrained Mr Hall. They used handcuffs, leg restraints and a contamination hood during the restraint.

59. At 10.18am, police officers and detention staff placed Mr Hall in his cell. He was still in handcuffs and leg restraints. Detention staff telephoned for an ambulance, which took Mr Hall from custody at 10.50am.

60. Mr Hall arrived at HRI at 11.05am and received treatment. He was still in police custody and, on arrival, wearing handcuffs and leg restraints.

61. Mr Hall suffered a cardiac arrest and was pronounced deceased at 12.45pm on 13 September 2016.

The decision to arrest Mr Hall and transport him from Huddersfield Royal Infirmary to the custody suite at Huddersfield police station

62. A member of staff at HRI telephoned the police at 7.01am to report that Mr Hall had assaulted a member of staff and had spat at his partner. The police control room despatched Officer Q to the hospital, with Officers J and K following a few minutes behind in a different vehicle.

63. The IPCC recorded a statement from Officer Q, in which they explained that on arrival at HRI, hospital staff told them that Mr Hall had assaulted a nurse and locked himself in a toilet. A number of medical staff, and Mr Hall's partner, were in the corridor outside the toilet. Officers J and K arrived before Officer Q saw Mr Hall.

64. In their prepared statement, Officer K explained their considerations of the situation:

'I needed to assess how best to deal with him. My main concern was, was he fit to be released from hospital or did I need to remain with him to ensure his behaviour did not continue, or could I deal with the allegations in another way, at another time.'

65. In interview, Officer K told the IPCC that they spoke to the doctor who was present, who told them:

'… words similar to "Get him out of hospital.'"

Officer K stated they asked the doctor three times if Mr Hall was fit to be released and the doctor replied with:

'… words similar to, "yes, he is fit to be released. He is fit if he can run around slapping people."

66. The doctor carried a personal name stamp, which he used to stamp his details in Officer K's pocket notebook (PNB): *'Dr A...'* An IPCC investigator seized this stamped page from Officer K's PNB during the PIP.

67. Officer J provided a statement to the IPCC, in which they said they spoke to a nurse who was present, who told them Mr Hall had taken an overdose of tablets

and alcohol the night before, and was admitted to hospital at 1.00am. Officer J stated that the nurse told them Mr Hall had taken:

'Roughly 25 tablets, a combination of Amitriptyline 25mg and Co-codamol 30/500mg.The doctor insisted he was fit to leave.'

68. Officer J recalled Dr A saying:

'… words to the effect of "Get him out of here… If he's fit to spit and slap he's fit to go.""

69. Dr A provided a statement to HM Senior Coroner. The IPCC obtained a copy of this statement. Dr A explained the medical treatment Mr Hall had received following his admission to HRI, for an *'unintentional overdose'* of *'25mg tablets of Amitriptyline x14 and 30/500mg Co-codamol.'*

70. Dr A spoke with Mr Hall after colleagues told them that he had assaulted a nurse. They recalled Mr Hall told them that he was going to go home:

'I was able to assess that Mr Hall had capacity to make decisions about his medical treatment. He was fully alert and responded appropriately to questions I asked him, he held eye contact and appeared to be orientated to where he was and what was happening… There was no reason to doubt Mr Hall's capacity to refuse treatment and self discharge.'

71. Dr A explained their considerations at this time:

'Mr Hall had made it clear that he was going to leave the hospital and I had no doubt he would have done so if he had not been arrested and taken to the police station. Although ideally I wanted Mr Hall to remain in hospital and finish his treatment I did feel that he would actually be safer in the police station than he would be if he went home.'

72. I recorded a further statement from Dr A, in which they explained their involvement with Mr Hall. They stated they did not believe they were able to persuade Mr Hall to remain in hospital, and his action of leaving the resuscitation room and waiting in the toilet indicated he *'… was on his way out of the hospital.'* Dr A told the police officers that Mr Hall's refusal of treatment had led to his discharge from the hospital.

73. Officer K did not reference in their statement or responses to the IPCC that Dr A had told them that Mr Hall had self-discharged. Officer J could not recall any reference to Mr Hall self-discharging. Despite this discrepancy, Dr A's account is consistent with Officer J and K's accounts, in that Dr A told the police that Mr Hall was able to leave the hospital and be taken to the custody suite.

74. Officer K spoke to Mr Hall after they had spoken to Dr A. They stood in the doorway of the toilet containing Mr Hall. They stated that as they talked to him, Mr Hall lifted the lid off the toilet cistern and raised it above his head. Officer K believed Mr Hall might throw the cistern lid at them, and instructed him to put it down. Mr Hall did so. Officer J also recalled Mr Hall '*fiddling with the lid of the toilet'* and then leaving it alone when instructed. Officer J stated Mr Hall was completely calm.

75. Officer K explained at interview with the IPCC that when Mr Hall lifted the cistern lid in this way, they believed it was in a threatening manner. They decided it was necessary to arrest Mr Hall. Officer K also said in interview that Mr Hall's partner was not present in the toilet when Mr Hall lifted the cistern lid, as:

    '*They were coming and going from the toilet during the time I was there, several times. I don't know where they were going.'*

76. Officer K explained to the IPCC the reason they arrested Mr Hall:

    'His arrest was necessary for a prompt and effective investigation, to prevent further injury and safeguard the victim of the assault and any other person he may come into contact with while at hospital. I believe that arresting Mr Hall was the right decision.'

77. Mr Hall's partner explained in their statement that Mr Hall had spat on them at the hospital, before he *'slapped a nurse.'* They did not mention him lifting the cistern lid.

78. IPCC investigators obtained CCTV footage of Mr Hall's time at HRI. The footage shows Mr Hall stood in a corridor of the A&E department with his partner and a number of hospital staff. At 6.55am and 58 seconds, Mr Hall appears to turn and face one of the nurses and raise his right hand and strike her across her face. The CCTV did not capture any footage of inside the toilet.

79. Officer Q recorded a witness statement from Nurse B, for the police investigation into the alleged assault, which the IPCC obtained. Nurse B stated that Mr Hall had spat at his partner, then:

    'Slapped me across the face with a cupped hand. He hit me to my left cheek. This caused immediate pain.'

80. Officer K recorded a witness statement from Nurse C for the police investigation into the alleged assault, which the IPCC obtained. Nurse C also stated that Mr Hall had spat at his partner, and then struck Nurse B across their face.

81. A WYP officer recorded a witness statement from hospital security officer Mr A, for the police investigation into the alleged assault, which the IPCC obtained. Mr A also stated that Mr Hall had hit Nurse B across the face. Mr A also recalled Dr A telling the police Mr Hall was fit enough to leave the hospital.

82. The CCTV did not capture an audio recording of Mr Hall's time in hospital, but the video footage is consistent with the accounts of Nurse B and Nurse C. The footage is also consistent with the information hospital staff gave to Officers Q, J and K about the allegation of assault.

83. The CCTV footage does not show the inside of the toilet and does not capture Mr Hall lifting the toilet cistern lid, as Officer K described. The footage does show Mr Hall's partner leave the toilet at 7.13am and 20 seconds, and briefly stand in the corridor. It is unclear from the footage whether the inside of the toilet is in their field of view. Officer K can be seen stood by the toilet door at this

time. Officer J is inside the toilet or toilet doorway and is not visible on the footage.

84. Two nurses and a security officer provided accounts that Mr Hall had struck Nurse B, and there was CCTV coverage of the incident. Dr A advised Officers J and K that Mr Hall was fit enough to leave the hospital. While the lawfulness of any arrest is ultimately a matter for a court having heard all of the evidence, it is my opinion that the available evidence tends to support Officer K's stated belief that it was necessary to arrest Mr Hall and take him from HRI to the custody suite, for the reasons the officer has given.

85. No misconduct notices were served in respect of Mr Hall's arrest and transport to Huddersfield police station because, in my opinion, there was no indication that any person may have committed a criminal offence or behaved in a manner that would justify disciplinary proceedings.

The actions taken to obtain medical assistance for Mr Hall at the custody suite

86. Officer K arrested Mr Hall at 7.20am at HRI, and arranged his transport to the custody suite at Huddersfield police station. Mr Hall arrived there at 7.30am and an officer took him to a holding area to wait to be booked in to custody.

87. The IPCC obtained CCTV footage recorded at the custody suite, providing an audio and video record of the entirety of Mr Hall's detention there.

88. Mr Hall sat in the holding area, accompanied by Officers J, M and L. Other detainees were present, but Mr Hall did not appear to interact with any of them. He spoke briefly to Officer J at 8.08am, who reminded him of the allegation that he *'slapped a Nurse.'*

89. Officer K entered the holding area at 8.21am. They later told the IPCC they had remained at the hospital to record a statement from a nurse who witnessed the alleged assault. Officers L and M left the holding area when Officer K arrived.

90. At 8.35am, Officer K took Mr Hall from the holding area to the custody desk. Officer J had left the holding area at 8.32am.

91. As custody officer, Officer C was responsible for booking Mr Hall into custody. At interview, they explained that Mr Hall had needed to wait in the holding area because the custody suite was full at the time of his arrival, and they were already attending to other matters. They believed they spoke to the officers who had arrived with Mr Hall whilst they were in the holding area, to understand the circumstances of his arrest.

92. Officer C's first action upon seeing Mr Hall at the custody desk was to request some trousers for him, as he was dressed in only his underwear and a t-shirt. Officer K told Officer C that Mr Hall had his trousers with him, but he had not put them on before leaving the hospital.

93. Officer C began to obtain Mr Hall's details and Officer K removed the handcuffs from Mr Hall that an officer had applied following his arrest at HRI. Officer K

began to remove Mr Hall's trousers from his bag, and Mr Hall indicated he felt unwell and was going to vomit. Officer C told Officer K to take Mr Hall to cell 13 to allow him to get dressed and to vomit. Officer K did so.

94. Whilst Mr Hall was in cell 13, Officer K arranged for water for him to drink. They asked Mr Hall:

"Are you alright for the nurse?"

Mr Hall's response was inaudible.

95. Officer K returned Mr Hall to the custody desk at 8.40am. They appeared to be concerned for him, and told Officer C:

"Sarge', he keeps saying he's not meant to be here. He took some tablets last night. I don't think he was planning on being here today."

96. Officer K explained to Officer C Mr Hall's circumstances: that he had been at A&E since 1.00am having *"taken some tablets."* They explained Mr Hall had appeared to spit at Ms Dyer and a nurse at the hospital, and then *"slapped that nurse around the face."*

97. Officer K told Officer C the information that Dr A had given them about the tablets Mr Hall had taken. Dr A had given the officers a piece of paper with the details of the tablets: co-codamol and amitriptyline. Officer K passed this to Officer C. This piece of paper was not retained, and neither officer still possessed it when IPCC investigators asked them at interview.

98. Officer C appeared to interpret the information on the piece of paper to indicate Mr Hall had taken *"about twenty-five tablets."* Officer J later stated that:

'Mr Hall had been admitted following the consumption of roughly 25 tablets, a combination of Amitriptyline 25mg, and Co-codamol 30/500mg.'

99. Officer C continued the booking in process, and at 8.43am and 37 seconds, said to Officer K:

"I'll get him to see our Nurse."

100. Officer K explained the circumstances of Mr Hall's arrest and the necessity for his detention. Mr Hall sat on a bench opposite the custody desk and appeared to fall asleep whilst Officers C and K spoke.

101. At 8.50am and 26 seconds, Officer C asked Mr Hall about the medication he had taken. Mr Hall said he had taken the tablets for *"pain relief* [and] *to get to sleep."* He told Officer C he had taken *"more than fifty"* tablets.

102. Officer C opened a custody record for Mr Hall, which included a risk assessment section. Officer C recorded:

'Overdose of 25 tablets at 2330hrs last night (co-codamol & amitriptyline) told to officers now states this is more than 50 tablets. Arthritis.'

Officer C also recorded that Mr Hall had drunk alcohol.

103. Officer B was a DO, and assisted Officer C with booking Mr Hall into custody.

104. In interview, Officer C explained their assessment that Mr Hall was medium risk and not high risk, had been influenced by their understanding that medical staff at the hospital had determined him fit to be released into police custody.

105. When Mr Hall was being booked in, Officer C determined he was fit enough to be detained, but due to him feeling *'sick and unwell'* was not fit to be interviewed.

106. Officer C recalled in interview that Nurse A might have been present at the custody desk when Mr Hall was booked into custody, and indicated to them that:

    'On the face of it, he looked alright.'

    Officer C acknowledged this comment, which they believed Nurse A may have made, did not constitute a medical examination.

    Nurse A did not reference in any of their statements that they were present at the custody desk when Mr Hall was being booked in.

107. Officer C recorded on the custody record that Mr Hall needed to see a health care professional to assess if he was fit to detain and fit to interview, and arranged for Nurse A to assess him. The custody log times this decision as 9.02am. Officer C recorded that custody staff were to check Mr Hall every 30 minutes, to rouse him so he responded. Officers escorted him to a cell with a camera to allow custody staff to monitor him from the custody desk. Officer C recorded the rationale for this:

    'Due to drink/overdose.'

108. In my opinion, the available evidence suggests the actions taken to obtain medical assistance for Mr Hall when he was booked in to custody were appropriate. Officer C learned of the quantities and types of medication he had taken, and the opinion of Dr A at the hospital. They recorded a risk assessment on the custody log detailing this information and their assessment of how Mr Hall appeared to them. They sought medical assistance by requesting the custody nurse see Mr Hall. Officer C ensured detention officers monitored Mr Hall by placing him in a camera cell and instructing them to rouse him at least every 30 minutes.

109. At 8.59am, after he was booked in to custody, Officer B and Officer K took Mr Hall to his cell. Officer D checked on Mr Hall at 9.10am, and then again at 9.33am.

110. Nurse A stated that at 9.45am, they began to assess Mr Hall by reviewing computer medical records and the information Officer C had recorded on the custody record. Nurse A then asked Officer E, a DO, to bring Mr Hall to the medical room.

111. Officer E stated that Mr Hall declined to leave his cell and go to the medical room. They informed Nurse A of this, who decided to visit Mr Hall in his cell and conduct a cell assessment. Nurse A stated:

'It quickly became apparent to me that he was unwell, and appeared to be drug intoxicated. He was disorientated and not obeying orders.'

112. Nurse A further stated:

'I have seen amitriptyline overdoses before, and when I saw Mr Hall, red lights were flashing for me… I could see the symptoms of such an overdose in Mr Hall.'

113. Nurse A and Officer E took Mr Hall to the medical room and Nurse A continued their assessment:

'He was having trouble processing my requests, and appeared vague and disorientated… I concluded that he was not in a fit state to be detained in custody and needed to be returned to hospital.'

114. Nurse A continued:

'Mr Hall suddenly got to his feet and pressed the panic alarm strip on the wall by the desk… I have no idea why he pressed it. I thought maybe he wanted to leave the room and he thought it was a door release. This was just my speculation.'

Nurse A recalled detention staff responding to the alarm activation. They shouted to them that it was a *"false alarm."*

'Mr Hall walked out of the room and straight to the panic alarm strip across the corridor, which he pressed.'

Three custody staff took Mr Hall from outside the medical room and back towards his cell.

115. In my opinion, the available evidence suggests the actions taken to obtain medical assistance for Mr Hall during his detention and prior to his restraint, were appropriate. Nurse A commenced their assessment of Mr Hall at 9.45am, before visiting him in his cell at 10.03am. Nurse A explained they have a contractual target to see detainees within one hour of the request. The available evidence shows that they met this target.

116. Shortly after officers had taken Mr Hall from the medical room, Nurse A responded to a *'commotion'* they heard in the corridor:

'I went to the corridor and saw Mr Hall restrained on the floor by a number of detention officers and police officers. The custody inspector was stood over him, I concentrated on Mr Hall. I crouched down in front of him to check his breathing, colour and all physical symptoms. He was not showing any sign of

asphyxia or excessive restraint. His breathing was not restricted or compromised, and he was shouting a lot.'

Nurse A continued:

'I went to the custody desk and told them my assessment and that Mr Hall needed to go back to A&E, and an ambulance should be called. It was not safe for him to remain at custody.'

117. Nurse A stated that they telephoned the A&E department at HRI and expressed their concerns about Mr Hall to a consultant, who *'… agreed to readmit Mr Hall…'* Nurse A speculated they might have made this telephone call after officers had restrained Mr Hall in the corridor.

118. Nurse A entered their medical assessment onto the custody record at 10.45am. This was after Mr Hall's restraint in the corridor and the cell, and included Nurse A's observations of Mr Hall during that incident, and the conversation held with the A&E consultant.

119. At 10.38am, a detention officer recorded on the custody log that an ambulance had been requested *'on the advice of Nurse A.'* The Yorkshire Ambulance Service (YAS) log timed this call at 10.35am.

120. The paramedics arrived in the custody suite by 10.42am. Nurse A described their interactions with them:

'I spoke to the Paramedics when they came into custody and told them he was expected at A&E and they needed to get him straight there. I told them he was behaving aggressively and was being restrained. He was uncooperative and *they shouldn't waste their time getting observations, but to take him straight away.'*

121. The paramedics, and police and detention officers placed Mr Hall on an ambulance stretcher, and he left the custody suite at 10.50am.

122. The available evidence suggests the actions taken to obtain medical assistance for Mr Hall following his restraint were appropriate. Nurse A checked on Mr Hall when officers were initially restraining him in the corridor. They then contacted HRI A&E department to discuss their concerns and belief Mr Hall should return to hospital. They advised Officer C of their opinion, who then arranged for an ambulance to be called. No misconduct notices were served in respect of the actions taken to obtain a medical assessment for Mr Hall because, in my opinion, there is no indication that any person may have committed a criminal offence or behaved in a manner that would justify disciplinary proceedings.

The use of force by officers at the custody suite during Mr Hall's detention

The panic alarm activation

123. When Mr Hall activated the panic alarm strip in the medical room, three detention staff hurried there.

124. Officer C was at the custody desk and realised from the alarm panel that the activation had been in the medical room. They ran to the medical room, with Officer E and Officer G.

125. The custody suite CCTV does not capture audio or video from inside the medical room. At 10.09am and 58 seconds, an alarm goes off. As Officer C, Officer E and Officer G arrive in the corridor outside the medical room, Nurse A can be heard:

"False alarm. False alarm. He triggered it himself."

126. Officer C said in interview that they did not know it was Mr Hall in the medical room until they arrived there. They attempted to prevent Mr Hall from activating the panic alarm in the corridor outside the room. Officer C explained their assessment of the situation:

'I was concerned he was in this agitated state that I thought he was going to become aggressive… The way he looked, he wasn't listening…'

127. Officer C took hold of Mr Hall's right arm in a *'goose neck,'* which involved holding his arm and hand, bending his hand inwards at the wrist. In interview, they explained:

'You could hear him heavy breathing, his hands were clammy. I tried to put his hand up his back initially and there was no way I could do that, he was so strong.'

128. Officer C explained that they considered *'impact factors:'* Mr Hall was much bigger than they were, and they were aware of his hospital admission for an *'overdose'* and that he had assaulted a nurse there. They described Mr Hall *'resisting:'*

'Moving his hand around to presumably try and get out of the hold that I had.'

129. Officer C explained *'impact factors'* was an *'old term'* they recalled from police training. In this case, they used the term to describe their belief that they were at a disadvantage in dealing with Mr Hall.

130. The audio of the CCTV footage captures Nurse A advising Officer C at 10.10am and 16 seconds:

"He's not cooperating at all."

131. Officer G hurried to the medical room with Officer C and Officer E.

132. Officer G was not present when Mr Hall was booked in to custody. In interview they explained their knowledge of him:

'He has come from hospital, he has allegedly assaulted staff.'

133. When Officer G arrived at the medical room, they understood from Nurse A, that Mr Hall had activated the panic alarm. They explained their assessment:

'My thoughts at that time was that he needed to go back into his cell.'

134. Officer G recalled that Officer C had spoken to Mr Hall when they arrived:

'… the words were something like "come on, lets be having you. You can't be doing that." Or words to the effect of "what's the matter?"'

135. In interview, Officer G gave their rationale for taking hold of Mr Hall's right arm:

'He had a vacant look to me. There was just no understanding whatsoever of what was being said or done and the simplest and safest option for all of us, including him and anybody else in the cell area, was to have him back in the cell. Which is where, according to Code C of PACE, is the appropriate place for him to be detained, as opposed to the corridor.'

136. Officer E hurried to the medical room, and recalled Nurse A saying the panic alarm activation was a *'false alarm.'* They recalled Mr Hall then attempted to activate the panic alarm in the corridor outside the medical room.

137. Officer E stated that Officer C asked Mr Hall to go back to his cell, but:

'He became obstructive and squared up.'

In interview, Officer E explained that Mr Hall pulled himself tall and broadened his shoulders. This was what they meant by him *'squaring up.'*

138. Officer C and Officer G did not describe Mr Hall *'squaring up'* at this time, or pulling himself tall and broadening his shoulders.

139. Officer E described that when Officer C and Officer G took Mr Hall's arms, they placed their hand on his back to:

'Guide him back down the corridor [using] *no force at all.'*

Officer E described how they could feel Mr Hall *'tensing up'* as they walked him down the corridor to his cell.

140. The CCTV footage shows the three officers walked Mr Hall back to his cell. Officer C appears to hold Mr Hall's lower right arm and hand; Officer E appears to hold his upper left arm; and Officer G appears to be holding Mr Hall's back and possibly his left hand.

141. In my opinion, the available evidence suggests that the initial actions taken by Officers C, E and G to return Mr Hall to his cell were in line with their training. Nurse A had finished their medical assessment and advised that Mr Hall needed to be returned to hospital. There appeared to be no reason for Mr Hall to remain out of his cell. Mr Hall had activated a panic alarm in the medical room, and then appeared to attempt to cause a further activation in the corridor outside the medical room. The evidence suggests that he was disorientated and not responding to verbal commands. Mr Hall was in detention and this was taking place within the custody environment, where any loss of control can have serious and significant consequences. In my opinion, in this context, Officer G's rationale that '*the simplest and safest option for all of us, including him and anybody else in the cell area, was to have him back in the cell*' seems reasonable. In addition, the officers were aware that Mr Hall had assaulted a nurse earlier that evening.

142. While Officer E's account that Mr Hall *'squared up'* to Officer C is not corroborated by the other officers, all officers describe Mr Hall as tensing up and resisting as soon as Officer C took hold of him. The officers' recount using minimal force backed up by verbal commands to lead Mr Hall away from the medical room. Their verbal commands can be heard on the custody CCTV recording and there is no evidence to suggest a greater degree of force than the officers describe was used at that point. For these reasons, it is my opinion that there is no indication that the force used by any officer up until this point was excessive. Consequently, the misconduct notices served on these officers did not allege any misconduct in relation to this part of the incident.

The restraint in the corridor

143. The CCTV footage shows that as the officers walk Mr Hall down the corridor leading to cell 13, they approach a blue barred gate, which is in the open position, allowing passage down the corridor. The gate appears securely fastened to the corridor wall in the open position. Mr Hall appears to free his right arm from Officer C's grip and he takes hold of the barred gate. This occurs at 10.10am and 40 seconds.

144. Officer C can be heard saying "*get off."* Officer C appears to strike Mr Hall's right arm with their right hand five times.

145. Officer E appears to let go of Mr Hall's left arm and appears to use their right hand to strike Mr Hall's right arm eight times.

146. Officer G appears to attempt to pull Mr Hall backwards away from the gate.

147. At 10.10am and 42 seconds, Officer D enters the corridor and rushes towards Mr Hall and the three officers. They appear to take hold of Mr Hall's head or shoulders.

148. The four officers and Mr Hall engage in a struggle.

149. Officer G appears to strike Mr Hall's legs with their left knee three times.

150. Voices can be heard:

"Give up, cut it out."

"Give up, get off."

"Get off of it."

151. At 10.10am and 54 seconds, it appears Mr Hall is no longer holding the barred gate. He appears to be swinging his arms at the officers, in particular, Officer D. Between 10.10am and 55 seconds, and 10.10am and 58 seconds, it appears Mr Hall strikes Officer D twice to the head with his left hand.

152. At 10.10am and 57 seconds, Officer E appears to use their right leg to kick at Mr Hall's legs.

153. At 10.11am, Officer D appears to strike Mr Hall's head with their right hand five times.

154. At 10.11am and 4 seconds, Officer C activates an alarm panel strip on the corridor wall and an alarm goes off. It is difficult to hear voices after this point. Mr Hall drops to his hands and knees on the floor.

155. At 10.11am and 5 seconds, Officer D appears to strike Mr Hall's head or shoulder three times with their right hand.

156. At 10.11am and 13 seconds, Officer B and Officer F arrive in the corridor and kneel in front of Mr Hall. Because of the number of officers present, it is difficult to see clearly what they are doing. There are now six officers holding Mr Hall down on the floor.

157. Officers apply handcuffs and Velcro fastening leg restraints to Mr Hall, though it is difficult to see which officers carried out these actions.

158. At 10.13am and 7 seconds, Nurse A stands watching the prone Mr Hall. Other officers have also arrived in the corridor.

159. At 10.13am and 56 seconds, Mr Hall appears to raise his head and shoulders off the floor and then strike the left side of his head twice against the floor.

160. At 10.14am and 16 seconds, someone passes a blue pillow to the officers and they place it underneath Mr Hall's head.

161. Mr Hall is shouting and making noises throughout the incident, only some of which is audible:

"I want, I want a lawyer…

"You're fucked. Now let go of me and we'll cut a deal…

"You're fucked. I'm, I'm buzzing…

"You're all fucked…

"Police you're fucked."

162. At 10.16am and 45 seconds, a male voice says:

"He bit the Inspector. Unbelievable."

163. At 10.17am and 52 seconds, a female officer places a contamination hood on to Mr Hall's head.

164. At 10.18am and 24 seconds, the officers lift Mr Hall and carry him into cell 13, a distance of less than ten metres. Mr Hall is carried feet first, on his left side, with three officers holding his legs and feet, and two officers holding his arms and shoulders, supporting his head. Five blue mattresses were on the floor and bench of the cell, in what appears to be a makeshift attempt to pad the cell.

Officer C

165. In interview, Officer C explained why they had struck Mr Hall's arm:

'In order to get it off… I felt he was going to offer immediate violence… if I didn't get it off quickly… any three of us that were there could have been assaulted by him. That's what I felt… I thought that was the most appropriate way to get him under control again, so that nobody was going to get hurt.'

166. Officer C described how they had struck Mr Hall:

'I hit him on the forearm… I've gone by my training… a bottom fist strike… there's some nerves in the arm that will, if you hit those nerves, he'll release the grip…'

167. Officer C explained why they did not believe verbal commands were appropriate, prior to using a higher level of force in striking Mr Hall:

'I thought that was the least impactive thing I could do… because I felt as though he was going to immediately offer violence… and I didn't want to give him the opportunity to, because I thought somebody would be seriously injured.'

168. Officer C said three sets of leg restraints were used on Mr Hall, as one set could not be applied tightly. Officers applied the two other sets one above and one below Mr Hall's knees.

169. Officer C described how officers used two sets of handcuffs by interlocking them together, with one set attached to Mr Hall's left wrist, one set attached to his right wrist then both sets fastened together behind his back. This widened the gap between his hands behind his back:

'To try and aid him and to make sure he was breathing properly.'

170. They explained why they had authorised the use of a contamination hood:

'Spitting is particularly nasty and I knew he'd got a propensity to spit because that's what he'd tried to do at the hospital.'

171. Officer C provided a rationale for their use of force which, in my view, is clear and appears to be consistent with other available evidence. It is implicit in their account that they considered verbal commands alone would not have caused Mr Hall to release his grip. There is strong evidence to support the contention that Mr Hall was not responding to verbal commands. Officer C explained their belief was that Mr Hall was going to become violent and they needed to regain control of him and the situation. That stated belief must be viewed in light of what they knew about the earlier alleged assault by Mr Hall on a nurse. It must also be viewed in light of the relative strength and size of Mr Hall, which Officer C has stated influenced their decision-making. The method they used to strike Mr Hall is known as a dysfunction strike and is taught within officer safety training. There is no evidence to contradict their account that the sole purpose of the strikes to Mr Hall's arm was to cause him to release his grip. Officer C explained they used multiple strikes as each successive strike was ineffective and Mr Hall did not release his grip of the gate bar. The CCTV footage supports this explanation.

172. Officer C continued to use verbal commands to Mr Hall whilst they were striking him. In my opinion, this suggests they were trying to calm the situation and regain control of him that way. They authorised the use of handcuffs and leg restraints to facilitate keeping him under control, and appeared attentive to his welfare by directing the placing of mattresses across his cell floor.

Officer E

173. In interview, Officer E recalled Mr Hall taking hold of the metal barred gate. They stated that they struck his forearm with the side of their hand and not their fist:

'Which is what we are trained to use... It's a trained technique that we're shown and trained in training school, to try and get the nerve for him to release his grip on the bar

174. They gave their rationale for striking Mr Hall's arm:

'I was trying to get him to release his grip from the bar so we can take control back of him.'

175. Officer E recalled that Mr Hall had been told to *'get off'* the bar, but could not recall if they had said this as well as Officer C. They did not believe verbal commands would be effective and Mr Hall was not going to let go of the bar.

176. Officer E described the situation happening quickly. They considered:

'The safety of the officers, there's the safety of him, safety of other people around. Just get him back into the safety of his own cell… When something like that is happening you don't have time to step back and have a long think about it, cos by that point someone else could have been hurt.'

177. Officer E explained why they had struck at Mr Hall with their leg, but denied kicking him:

'I was trying to sweep his leg to help him onto the floor. But I don't believe I made any contact with him. I missed. My action was to try and sweep his leg to stop him from running off. If he'd have got off down that corridor, well then who knows.'

178. Officer E said the intention was to get Mr Hall onto the floor to regain control of him and allow them to apply leg and arm restraints.

179. In interview, Officer E acknowledged they had struck Mr Hall's leg with their hand whilst they were lying on top of his legs:

'To stop him kicking. He was that strong he was lifting me up off the floor. That's how strong. But that's the idea, to stop him lashing his feet around. I have hit him to try and get his legs to pull in.'

180. Officer E described using the bottom half of their clenched fist to strike at nerve areas in Mr Hall's calf. They did not believe it was effective, and he continued *'thrashing around.'*

181. Officer E was one of the officers who lifted and carried Mr Hall into his cell. They explained the reason why they had put blue mattresses on the floor of the cell:

'What we do if somebody's being violent, obviously we're going to be placing them onto the floor… you're not going to be placing them straight onto a stone floor or a surface, you would pad it out with other mattresses to stop them from hurting themselves.'

182. Officer E provided a rationale for their use of force that, in my opinion, is clear and appears consistent with the available evidence. Like Officer C, Officer E explained that they believed the safety of them and their colleagues was at risk, and they needed to regain control of Mr Hall. Once again, their belief needs to be seen in the context of their knowledge of the earlier alleged assault and the relative size and strength of Mr Hall. Officer E initially used a technique known as a dysfunction strike to Mr Hall's arm, using the base of their fist to strike at nerve points within his arm. Mr Hall did not initially release his grip and Officer E continued to strike him.

183. Officer E then attempted to use their leg to knock Mr Hall off balance, and then used a further strike with the bottom of their fist against his leg. Officer E's account and the CCTV footage suggest this was a further dysfunction strike attempt. WYP officers receive training in these techniques during officer safety training. The evidence indicates that once Mr Hall was under the control of the officers, Officer E made no further strikes on him. In my opinion, this supports Officer E's contention that their aim was solely to bring Mr Hall under control and that they used only as much force as they believed necessary to achieve that aim.

Officer G

184. In interview, Officer G explained why they had struck at Mr Hall with their knee:

'Mr Hall is resisting, he's not compliant. He's got hold of the furniture or another officer, or he's got hold of both, or he's moving between the two…. I'm concerned for my safety, the officer's safety and the fact that we need to get him onto the cell for everybody's benefit. An escalation of force is required… and the only thing I can think is most appropriate at that point in time, rather than letting go of him and doing anything else with my hands, is to use another approved technique which we're taught, which is called a knee strike.'

185. They did not think they made contact with Mr Hall when they attempted the knee strike: There appeared to be no effect on him; and they did not have any bruising or reddening to their knee the next day.

186. Officer G explained the purpose of their knee strike was to hit a muscle group in the centre of Mr Hall's thigh. They cited their training, that this was *'the designated target area.'*

187. Officer G did not believe they had made three knee strike attempts at Mr Hall. In interview, they viewed the footage a number of times and agreed they could see what appeared to be two attempts to strike Mr Hall with their knee. They

speculated a further movement of their left leg might have been them attempting to regain their balance.

188. Officer G confirmed that at some point during the incident, Mr Hall bit them on their calf, however, could not recall at what point this happened. After officers carried Mr Hall into his cell, Nurse A saw Officer G about this bite wound and advised them to go to the hospital. Officer G did so, and had no further involvement with Mr Hall during his detention at the custody suite.

189. Officer G provided a rationale for their use of force that, in my opinion, is clear and appears consistent with the other available evidence. They explained that they were concerned for the safety of themselves and their colleagues and they needed to use force to enable officers to return Mr Hall to his cell. Again, their stated belief must be considered in light of the broader circumstances highlighted in relation to the accounts of Officers C and E. Officer G's account is that they struck at Mr Hall with their knee in an attempt to regain control of him. This knee strike technique is one taught to WYP officers during their training. Regardless of whether Officer G attempted two strikes or three, it is apparent from the CCTV footage that none appeared to work in the way in which they intended. The evidence suggests that once the officers regained control of Mr Hall, Officer G made no further strikes at him. In my opinion, this supports Officer G's contention that their aim was solely to bring Mr Hall under control and that they used only as much force as they believed necessary to achieve that aim.

Officer D

190. In interview, Officer D described how they came into the corridor where Officers C, E and G were *'struggling'* with Mr Hall. They put their radio down and went to assist. They saw Mr Hall was holding onto a bar with his left hand and that:

'The officers didn't have any control over Mr Hall's right arm as well.'

191. Officer D explained why they took hold of Mr Hall's head:

'Two reasons: One is if I can move him towards me, he's in a position of disadvantage, I weaken his stance. And two, because I know that he's spat before with someone. I don't want him to spit in my face.'

Concerning weakening Mr Hall's stance, Officer D said this was something they had learned as part of their *'empty hands skill'* training.

192. Their objective in taking this action was:

'Ultimately I would have liked to have taken him to the floor, so control can be gained and then he could be safely then moved back into his cell area.'

193. In their initial PIP account, Officer D stated Mr Hall had *'swung… a punch at me.'* In their prepared statement, Officer D said that *'…his punch connected with my jaw.'* At interview, Officer D said Mr Hall had punched them twice to the right side of their jaw. They explained they noticed the next day *'…my face was really sore'* and realised Mr Hall's blows had made contact. They did not seek medical assistance for their sore face, but did report their injury to the post incident manager.

194. At interview, Officer D timed the punches from Mr Hall at 10.10am and 56 seconds on the CCTV footage. This was four seconds prior to Officer D appearing to strike Mr Hall.

195. In their prepared statement, Officer D described Mr Hall trying to grab their leg. At interview, Officer D viewed the CCTV footage and said this occurred between 10.11am and 1 second, and 10.11am and 3 seconds.

'It gave me serious concerns because… falling back on my head on the concrete floor could have serious effects on me. And if he lands on top of me… the strength of this man… there is not a chance I could have got him off… and if he'd started strangling me, he would have killed me there and then.'

196. I highlighted to Officer D that at the time when they thought Mr Hall was trying to grab their leg, they appeared to strike Mr Hall to his head five times with their right hand. Officer D replied:

'I don't believe they're strikes, punches. They're certainly not effective in any way. I don't know if I am… grabbing his arm or if I am striking, but they're not full blown punches.'

197. On further questioning, Officer D acknowledged:

'It could be a strike to his shoulder. I don't believe from the footage and from my recollection, I ever connected to his head.'

Officer D agreed the footage showed them pulling their arm back five times, with a bent elbow, and appearing to strike Mr Hall five times, between 10.11am and 10.11am and 4 seconds.

'I would continue until I gained control… no one was in control, I have to gain control of this man.'

198. Officer D maintained they did not aim any strikes at Mr Hall's head, but at his shoulder. They referenced their *'empty hands'* training referring to *'red zones,'* with the face being one such zone. Red zones, they explained, were *'delicate areas'* which should not be aimed for.

199. I asked Officer D if they had aimed for Mr Hall's shoulder but inadvertently hit his head:

'I've gone for his shoulder and I believe I've hit his shoulder.'

200. Officer D explained their considerations of the situation and why they resorted to striking Mr Hall:

'I haven't really got any other option. I can't walk away because… Mr Hall would have broken free of those officers and then God knows what would have happened.'

Officer D could not recall if they were speaking to Mr Hall at the time.

201. At 10.11am and 5 seconds, it appears from the CCTV footage that Officer D strikes Mr Hall with their right hand towards his head and shoulder, whilst Mr

Hall is on his hands and knees. At interview, Officer D believed this was only one strike. They explained this was to Mr Hall's *'arm and shoulder.'*

'His arm appears to be tucked under him and I am trying to dislodge it so I can take hold of it… to control it… then he could be handcuffed.'

202. Officer D did not believe Mr Hall responded to the strikes they had made:

'He had a diminished sense of pain… he was just so incredibly strong.'

203. When I asked them, Officer D denied losing their temper and believed they were in control of their actions.

204. Officer D arrived in the corridor outside Mr Hall's cell after the incident had already started, so the circumstances on which they made their assessment were different to that of Officers C, E and G. Although, it appears they were aware that Mr Hall had allegedly assaulted someone and spat at another person earlier that evening. Officer D stated that they believed control of Mr Hall had already been lost at this point, and it was necessary to regain it. In my opinion, their initial actions appear from the available evidence to be in accordance with the training they had received, in that they attempted to upset Mr Hall's balance.

205. The CCTV footage does appear to show Mr Hall striking at Officer D. This supports their account that they were struck twice in the face. Officer D's stated belief that they were under attack from Mr Hall provides a justification for them to respond in order to protect themselves and to protect others. Officer D disputes that they aimed for or struck Mr Hall to the face or head. It would appear from the CCTV evidence that Officer D's response was to strike at Mr Hall's head or shoulder with their right hand.

206. After Mr Hall dropped to his knees, Officer D appeared to make three further strikes to Mr Hall. They justified this on the basis that they needed to gain control of his arm. The evidence strongly suggests Mr Hall was not under control at this time. In my opinion, this supports Officer D's contention that there was still a necessity for them to use force to defend themselves and others and to gain control.

207. It would appear from the CCTV footage that, once Mr Hall was under the control of the officers, Officer D did not make any further strikes. In my opinion, this supports Officer D's contention that their aim was to defend themselves and the other officers and to bring Mr Hall under control, and that they used only as much force as they believed necessary to achieve that aim.

208. Officer D stated that they believed they made all their strikes towards Mr Hall's arm and shoulder. It is unclear from the CCTV footage exactly where Officer D struck Mr Hall, though it would appear to be the head or shoulder area.

209. West Yorkshire Police's officer safety training specifies the head as a *'target area'* and that*:*

'… operationally any of the target areas may be struck dependent on what the officer perceives as reasonable and appropriate in the circumstances, in compliance with all the relevant legislation relating to use of force.'

Mr Hall's cell

210. At 10.18am and 24 seconds, Officers C, D, E, K and N lifted and carried Mr Hall into his cell. He was wearing leg restraints, with his hands handcuffed behind his back. Four additional mattresses were on the floor of the cell, in addition to the mattress across the cell bench. Other officers were also present.

211. The officers placed Mr Hall on the mattresses lying on his left side.

212. Officer J laid across Mr Hall's lower legs and feet. Officer N knelt behind Mr Hall's head and shoulders, appearing to be holding him down. Officer K knelt behind Mr Hall level with his waist, also appearing to be holding him down. Officer O knelt in front of him at waist level. Because of the position of the other officers, it is unclear if Officer O is holding Mr Hall. The other officers leave the cell.

213. Officer C explained why the extra mattresses were placed in the cell:

    'To make sure that he's comfortable and to make sure that he's not gonna self harm again.'

214. Officer C further explained that they kept Mr Hall restrained in the cell because of his behaviour in the corridor during his initial restraint. He was on his side to reduce the risk of positional asphyxia.

215. I recorded a statement from Officer N, who also considered positional asphyxia:

    '… because he was heating up so much and because of his erratic behaviour. I did not want his airway restricted and I wanted to cool him down. We tried to keep him off his stomach, like in a recovery position. We wanted to keep pressure off his lungs and diaphragm. We tried to keep him centred in the cell to keep him away from the bench and walls.'

216. Officer N described Mr Hall's behaviour in the cell:

    'Mr Hall tried to harm himself in the cell by banging the front side of his face on the floor. I cannot recall how often he did this. At one point Officer K and I tried to calm him down by sitting him up by the wall by the toilet, but Mr Hall banged his head against the wall.'

217. I recorded a statement from Officer O, who recalled:

    'There were blue mats on the floor and Mr Hall tried to wriggle off them and bang his head on the floor… At one point we tried to sit him up so I could speak directly to him, to see if he would come round and calm down. Mr Hall banged his head backwards against the wall at least two or three times. I do not think he did this massively hard as there was not the sickening sound of head banging.'

218. Officer J also recalled Mr Hall attempting to hit his head:

    'He threw his head back against the wall at least twice, but I am not sure how much contact he made. It looked like he wanted to hurt himself.'

219. Officer K described Mr Hall's behaviour:

'We sat him up against the wall close to the opening leading to the toilet; he then swung his head backwards banging it on the wall. This was done in a very violent manner; I thought he was going to cause himself a serious injury. We attempted again to release him and allow him to lie on the floor, once released he again began banging his head on the floor.'

220. The CCTV footage appears to show Mr Hall attempting to hit the front of his head against the floor on a number of occasions: 10.44am and 12 seconds; 10.46am and 10 seconds; 10.46am and 57 seconds; 10.47am and 34 seconds. He also appears to strike the wall with his head at 10.40am and 58 seconds. This would appear to be the incident described by Officers N, O and K.

221. The officers attempted to give Mr Hall some water while he was in the cell. It is not clear from the CCTV footage whether they were able to get him to drink. Officer K described that Mr Hall would not take the water, so they followed Officer O's suggestion and *'slowly poured the water over his head'* to try to cool him down. Mr Hall appeared to drink the water that pooled in front of him.

222. At 10.43am and 34 seconds, Officer J placed an electric fan in the doorway of the cell, pointed at Mr Hall. They explained:

'I decided to fetch a fan to help him cool down. I have been taught about excited delirium and the need to keep people cool.'

Officer N believed they made the suggestion for the fetching of the fan:

'He was burning up and I didn't think he was calming down. I was concerned for his welfare.'

223. The CCTV did not record any audio from inside the cell, but the camera covering the adjacent corridor did capture some audio from the cell. Mr Hall was shouting for much of this time, only some of which was comprehensible:

"They're beating me on the floor…

"Stop, get off me…

"Please stop killing me. Please stop killing me. It's Andrew Hall…

"I'm going to die tonight in Huddersfield police station…

"Help me please. Help me please. I'm getting murdered."

224. IPCC investigators reviewed the audio recorded by the corridor CCTV against the images captured by the cell CCTV. Despite Mr Hall's shouting, the available evidence does not corroborate his claims that officers were beating him in the cell or that anyone was trying to murder him. The officers' actions, as detailed in the previous paragraphs, suggest that they were attempting to restrain him on the floor and prevent him from self-harming whilst also being mindful of his welfare. This appears to be demonstrated by such actions as their consideration of his position on the floor, the laying of extra mattresses, the obtaining of a fan to try and keep him cool and offering him water.

225. At 10.47am, the paramedics arrived at Mr Hall's cell, ready to transport him to hospital.

226. No misconduct notices were served in respect of the restraint of Mr Hall when in the cell because, in my opinion, there is no indication that any person may have committed a criminal offence or behaved in a manner that would justify disciplinary proceedings. The available evidence suggests it was appropriate for the officers to keep Mr Hall restrained during his period in the cell prior to the ambulance arriving. He appeared to still be struggling and attempting to harm himself. I have found no evidence to suggest that the level of force used to restrain him while awaiting the ambulance was disproportionate.

In the ambulance

227. In their initial account to the IPCC, Officer K stated that in the ambulance:

'Hall is behaving irratic (sic) *and violent. He begins biting the mattress and eats the mattress. In order to prevent him damaging the mattress I used a distraction technique and punched him to his cheek area. It had no effect* [and] *he continued biting and eating the mattress.'*

228. There was no CCTV footage recorded in the ambulance as it travelled to the hospital. Due to issues of patient privacy, the ambulance CCTV system does not record automatically and it was not manually activated during this journey.

229. Two paramedics were in the rear of the ambulance attending to Mr Hall. With them were Officers K, N and O.

230. IPCC investigators recorded a statement from Paramedic A, an Advanced Emergency Medical Technician, who was one of the paramedics in the rear of the ambulance. They described that when Mr Hall was placed on the stretcher at the custody suite:

'.. [he] *was restrained. The stretcher straps were applied to stop the male hurting himself or others. I could see that he had a swollen black eye and injuries to his wrists that appeared to be from the handcuffs.'*

231. Paramedic A described Mr Hall's behaviour in the ambulance:

'The male was biting the stretcher mattress and tearing chunks out of it. I have never seen anything like it before. I cannot remember any officer using force on the male during the journey other than to restrain him. I have been directly asked if I witnessed an officer punching the male in an effort to stop him biting. I did not see this.'

232. IPCC investigators recorded a statement from Paramedic B, an Emergency Technician, who was also in the rear of the ambulance. Paramedic B stated that when they saw Mr Hall at the custody suite:

'I could tell that he was very sweaty and he was hot to the touch through my gloves. Mr Hall tried to struggle on the stretcher including spitting and trying to bite as he was wheeled to the ambulance.'

233. Paramedic B recognised Officer K, having *'…seen them before through work.'* They referred to them as '*Officer A'* in their statement.

234. Paramedic B described Mr Hall's behaviour in the ambulance:

'Due to Mr Hall wriggling and struggling he was laid mainly on his front with his head turned towards the cupboards on the offside of the ambulance. I was at the top of the stretcher within touching distance of Mr Hall's head and I had an unobstructed view of his head throughout the journey to the hospital…

Mr Hall would continually switch from being compliant to violent during the journey and used his mouth to bite and tear strips from the ambulance stretcher mattress. Due to this Officer A twice placed their right hand on Mr Hall's head and hair, and held his head onto the mattress in an attempt to stop him from biting. I never saw Officer A, or any of the other officers, punch Mr Hall.'

235. Officer N rode in the ambulance with Mr Hall. They recalled that they were by Mr Hall's feet by the rear door. They held Mr Hall's feet or ankles during the journey to prevent him from *'…lashing out.'*

236. Officer N stated:

'Mr Hall was biting the mattress in the ambulance. I cannot recall what point in the journey this was and he did not do this continuously… I cannot recall what Officers K and O did, who were in the ambulance by Mr Hall's head. I cannot recall speaking to Officers K and O about Mr Hall biting the mattress. I cannot recall speaking to the paramedics during the journey.'

237. Officer O was also in the ambulance:

'Mr Hall was shouting again about "they are killing me," or words to that effect. He was also biting the leather covered sponge covering of the stretcher. He bit through the outer cover. Officer K was at his head end and kept having to pull his head back, holding on to his jaw and the top of his head as he did so. I think Mr Hall may have swallowed part of the cover at one point.

I have been asked today if I saw Officer K strike Mr Hall. I did not see Officer K do this.'

238. In their prepared statement, Officer K denied using excess force against Mr Hall, believing their actions were *'reasonable and proportionate.'*

239. Officer K described Mr Hall's behaviour in the ambulance:

'… [he] *continued to struggle, his behaviour was erratic and violent. Hall then began biting the stretcher. I repeatedly told him to stop and attempted to role* (sic) *his head to one side to stop him.'*

240. They were not successful in moving Mr Hall's head, citing Mr Hall's *'… extreme strength and sheer determination.'* Officer K described how Mr Hall managed to tear off a *'strip'* of the vinyl mattress cover, which he *'… pulled into his mouth using his tongue, and it appeared he was trying to eat the material.'*

241. Officer K continued:

'I feared that if he swallowed the material it could cause him to choke and cause further health problems.'

They described that Mr Hall continued to bite the mattress and tore off a further piece with his mouth. Officer K did not describe what had happened to the first piece of mattress Mr Hall had bitten off.

242. Officer K offered a rationale for why they struck Mr Hall:

'In order to protect Hall and to prevent further damage to the property, I felt that it was reasonable to punch him to his left cheek area to distract him… a short sharp distraction technique.'

243. Officer K explained their considerations prior to striking Mr Hall:

'I did not feel comfortable placing my fingers into his mouth area because I was aware he had bitten an officer and I didn't want to be at risk of being bitten myself. I didn't consider the baton to be reasonable in the circumstances, and I didn't consider CS spray to be reasonable.'

244. At interview, Officer K provided further details about them striking Mr Hall in the ambulance. They described how initially they tried to roll Mr Hall's head:

'I've tried to roll his head by pushing on sort of the top of his head, to try to rotate his head, so his mouth wasn't in contact with the mattress.'

They attempted to push down on the crown of Mr Hall's head to lift his mouth away from the mattress. Officer K started these attempts after Mr Hall had begun to bite the mattress, and continued after he had managed to detach a piece. Officer K described being unsuccessful in these attempts to roll his head.

245. Officer K described the urgency to the situation:

'I've talked to him. I've pushed his head. All this is happening in a very, very short period of time. He's pulling material into his mouth. I've had to make split second decisions to protect him from harming himself. If he had got that in his throat, he's in handcuffs, we're in an ambulance, the outcome would have been very bleak – if we're in an ambulance and he's choking to death.'

246. Officer K did not consider using a pressure point technique as a method of stopping Mr Hall's attempts to bite the mattress:

'The problem with pressure points is you have to be bang on. And unless you're using them every day, they're very difficult to find. And when you've got someone struggling, they're even more difficult to find. And they don't always work either.'

247. Officer K believed their *'distraction punch'* did not work and Mr Hall swallowed the piece of mattress he had bitten into his mouth. They did not make any further attempts to stop Mr Hall as the ambulance arrived at HRI.

248. Paramedic A's and Paramedic B's accounts are consistent with Officer K's account, in that they all describe Mr Hall struggling in the ambulance and biting at the stretcher. Officers N and O also describe Mr Hall behaving in this way.

249. Paramedic B witnessed Officer K placing a hand on Mr Hall's head to attempt to move it and stop him biting the mattress. Officer O described Officer K holding on to the top of Mr Hall's head, also believing Mr Hall had swallowed part of the mattress cover. Paramedic B witnessed Mr Hall restrained in the ambulance, but did not describe Officer K specifically placing their hands on Mr Hall's head. Officer N stated they could not recall what their colleagues did during the journey.

250. Of the four people present in the ambulance with Officer K, none witnessed them striking Mr Hall. The only available evidence that Officer K struck Mr Hall was their own admission, made in their initial account at the PIP.

251. Officer K stated that they believed Mr Hall's safety was at risk due to his actions of biting and swallowing the mattress, and it was necessary to stop him. The evidence suggests that Mr Hall was indeed at such risk and there is no evidence to suggest any other motive on Officer K's part. They explained that trying to push Mr Hall's head away and talking to him had not worked, and their knowledge of Mr Hall biting another officer deterred them from using their own hands near his mouth. They stated that they considered it reasonable to strike Mr Hall in an attempt to distract him from his behaviour. They struck Mr Hall only once. When Mr Hall was unresponsive to the distraction strike, they did not consider it justified to strike him again.

The manner in which family members were informed of Mr Hall's death

252. IPCC investigators met with Mr Hall's family following his death. Family members expressed to the IPCC that they were concerned about the manner in which the police informed them of Mr Hall's death, and upset by some of the language used. In particular, the term *"crime scene,"* to describe Mr Hall's home address to his son.

253. No misconduct notices were served in respect of the manner in which family members were informed of the death of Mr Hall because, in my opinion, there was no indication that any person may have committed a criminal offence or behaved in a manner that would justify disciplinary proceedings.

254. Mr Hall's partner stated that they telephoned Huddersfield police station at 2.17pm on 13 September, to ask about Mr Hall's arrest and detention. A police officer telephoned them back at 2.37pm and asked them to go to Huddersfield police station. When they arrived there, a male and a female police officer took them to an interview room and told them of Mr Hall's death.

255. Mr Hall's partner recalled being in the room for *'about an hour and a half'* whilst the officers asked them questions about Mr Hall:

'If Andrew was on drugs, if and what Andrew drank and other questions which I cannot remember as I was in shock.'

They were told they were not under arrest, but needed to answer questions:

'I asked to leave the station 4 or 5 times and they said no, I needed to answer some questions. They were being firm when they told me I couldn't leave as the answers to their questions "all helped.""

256. Mr Hall's partner was taken to a second interview room and briefly met a further officer, before officers transported them back to a family member's house.

257. Officer T was a WYP officer, who was working on 13 September 2016 as the duty DI for the Kirklees district. They told the IPCC they were *'asked to coordinate the investigation of events prior to Mr Hall first attending hospital.'* They were involved in sending officers to tell family members of Mr Hall's death.

258. Officer U is a WYP officer, who was tasked on 13 September 2016, to inform Mr Hall's partner of Mr Hall's death. They went with a student constable to Mr Hall's partner's home address, but could not find them there. They telephoned them and arranged to meet them at Huddersfield police station. Officer U and the student constable took Mr Hall's partner to a *'quiet side room'* at the station and told them of Mr Hall's death.

259. Officer U updated the incident log at 2.40pm that they had spoken to Mr Hall's partner by telephone and arranged to meet them at the police station. They added a further update at 2.54pm that they had given them the news of Mr Hall's death. They then added an update at 3.03pm that recorded some of the information Mr Hall's partner had told them about Mr Hall.

260. Officer U stated that Mr Hall's partner had told them they wished to leave the police station, and they replied that:

"I'll need to speak to the DI first in case there is anymore information I can tell you."

Officer U spoke to Officer T and then asked Mr Hall's partner if they could *'stay 5 or 10 minutes'* as IPCC investigators were due to arrive at the station. They agreed.

261. Officer T saw Mr Hall's partner at the police station and explained to them:

'That we needed to find out what had happened and capture any evidence.'

262. IPCC investigators arrived at Huddersfield police station at 3.00pm on 13 September 2016. Shortly afterwards, an investigator met Mr Hall's partner and briefly spoke to them, before arranging for WYP officers to take them to a family member's home. The log records that Mr Hall's partner arrived there around 4.30pm.

263. The available evidence suggests the manner in which WYP officers informed Mr Hall's partner of Mr Hall's death was appropriate. Officer U arranged to meet with them at the earliest opportunity to give them the news in person.

264. Officer V and Officer W are WYP officers who were tasked on 13 September to inform Mr Hall's son of his death. They were also tasked to secure Mr Hall's home address and organise a search. The IPCC recorded statements from Officer V and Officer W

265. Officer V and Officer W went to Mr Hall's home address, met with Mr Hall's son, and told him of his father's death. They then travelled to the home address of Mr Hall's mother and told her the news.

266. I asked both Officer V and Officer W if they had used the term *"crime scene"* when talking to any of Mr Hall's family members. Officer W replied:

'I did not use this term. It is not one I would use anyway, and in this case, I did not want to intimate a crime had happened there. It is not an appropriate term to use.'

Officer V replied:

'I would not have said that. I am quite soft in my language and manner and would not have used that phrase given that we were there to inform him that his Dad had died.'

267. Mr Hall's partner's statement describes that it was the two officers who visited Mr Hall's son and told him of his father's death, who used the phrase *"crime scene."* This was Officer W and Officer V. Both officers stated they did not believe the phrase was appropriate in the circumstances and did not believe they used it when talking to Mr Hall's son. In this regard, the officers' accounts are contrary to Mr Hall's partner's account. There is no evidence to suggest, that if the officers did use the phrase, it was anything other than inadvertent.

268. Mr Hall's partner telephoned the police station on 14 September 2016, to ask for further information. A police officer, who she believed was *'Officer* X (name spelt incorrectly)*,'* telephoned her back. The officer told her that Mr Hall had died at 1.00pm the previous day. Mr Hall's partner later learnt the time of death was recorded as 12.45pm, and told the IPCC:

'Being provided with two conflicted times of death has upset the family greatly.'

269. Officer X is a WYP officer, who was appointed as Family Liaison Officer (FLO) for the Hall family following Mr Hall's death. I believe Officer X is the police officer who Mr Hall's partner named as Officer X (name spelt incorrectly). Officer X telephoned them on 14 September 2016, and recorded this contact in their FLO log. WYP have confirmed to me that they do not have an officer with the surname Officer X (name spelt incorrectly), which as pronounced, sounds similar to Officer X.

270. An IPCC investigator recorded a statement from Officer X, in which they could not recall if they discussed the time of Mr Hall's death when they telephoned Mr Hall's partner on 14 September 2017. They did not record in their FLO log that they had provided the time of death to them.

271. Mr Hall's partner's and Officer X's accounts are contrary: Mr Hall's partner believes an officer incorrectly advised them of the time of Mr Hall's death; Officer X did not believe they discussed it. The contemporaneous record they made in their FLO log of this telephone call does not refer to the time of death. I have found no evidence to suggest that if Officer X did advise Mr Hall's partner of the incorrect time of death, it was anything other than unintentional.

Medical evidence

272. Pathologist A conducted a post mortem examination of Mr Hall on 14 September 2016. They provided a statement in which they gave their opinion regarding the cause of death:

    'Ischaemic heart disease with codeine and paracetamol (co-codamol) toxicity and amitriptyline ingestion with periods of agitation and subsequent restraint.'

    Amitriptyline is a tricyclic antidepressant also used for the treatment of neuropathic pain and migraines. Co-codamol is an analgesic containing paracetamol and codeine.

273. Pathologist A noted injuries to Mr Hall's head and face: widespread bruising and swelling around his left eye and forehead, and swelling and bruising around his right upper eyelid. Pathologist A also noted bruising on Mr Hall's torso, legs and arms, and internal bruising to the back of his scalp.

274. Pathologist A referred to a toxicology report Toxicologist A prepared for them. They noted that codeine and paracetamol were present at levels above *'quoted therapeutic ranges.'* Amitriptyline was also present at *'therapeutic concentration'* levels.

275. They also referred to a neuropathology report Neuropathologist A prepared for them regarding Mr Hall's brain. Pathologist A noted that there was *'an absence of… unnatural pathology such as traumatic injury.'*

276. In addition, Pathologist A referred to the cardiac pathology report Pathologist B prepared for him, noting *'a significant coronary atheroma which is at a level liable to be implicated in a sudden death.'* They also noted *'myocardial scarring, in keeping with prior myocardial damage. This further increases the risk of sudden death.'* They highlighted that amitriptyline and opiates (including codeine), which were present, were also associated with an *'increased risk.'*

277. Pathologist A concluded that the cause of Mr Hall's face and head injuries '*could*' have been his own actions of striking his head. They did not believe there was evidence to suggest deliberate punches and kicks were the cause of the injuries.

278. Pathologist A concluded that:

    'Perhaps the most important factor in the death of Mr Andrew Hall was the presence of his previously unreported and undiagnosed severe underlying coronary artery disease with evidence of old, myocardial damage… Drugs such as amitriptyline and opioid analgesics have a significantly deleterious effect on the cardiovascular function.'

279. Pathologist A speculated that the onset of such cardiac failure could have caused *'anxiety, agitation, confusion and distress,'* which Mr Hall appeared to demonstrate during his detention at the custody suite.

280. Pathologist C conducted a second post mortem examination on 12 October 2016, on behalf of the Police Federation. They provided a statement saying Mr Hall's:

'… impact injuries to the head [were] *consistent with the self-inflicted injuries as described in the police station.'*

281. Pathologist C agreed with Pathologist A's assessment that Mr Hall's behaviour appeared to be the result of :

'… the effects of his coronary heart disease with consequent cerebral hypoxia from poor perfusion coupled with the effects of co-codamol excess with amitriptyline consumption.'

282. Pathologist A further stated:

'It is entirely possible that the restraint played no role in the death and that sufficient changes to cause death had accrued from the heart disease and medication use.'

283. Pathologist D also conducted a second post mortem examination on 12 October 2016, on behalf of Mr Hall's family. They provided a statement in which they supported the cause of death given by Pathologist A.

Conclusions

284. Below, I have set out my conclusions for the appropriate authority and Commission delegate to consider.

285. If there are to be court or disciplinary proceedings, it will be for the relevant panel in those proceedings to make final determinations. For example, where I conclude that a person subject to the investigation has a case to answer for gross misconduct, this does not amount to a legal determination that there has been gross misconduct. If a charge is then brought by the appropriate authority a misconduct hearing will hear the evidence, and make its own findings about whether the charge is proved or not.

286. After reviewing my report and considering my recommendations, the Commission delegate will decide whether any organisational learning has been identified that should be shared with the organisation in question. They may also recommend or direct, unsatisfactory performance procedures.

Misconduct

287. For each person under investigation, I must determine whether there is a case to answer for misconduct or gross misconduct. In other words, whether there is sufficient evidence upon which a reasonable panel properly directed, could find,

that the conduct of the person under investigation fell below the standard of behaviour expected of them.

288. Misconduct is defined as a breach of the standards of professional behaviour.

289. Gross misconduct is a breach of the standards of professional behaviour so serious that, if proven, dismissal would be justified.

Officer C

290. Based on the evidence presented above, it is my opinion that there is insufficient evidence upon which a reasonable tribunal, properly directed, could find gross misconduct in respect of Officer C for using a level of force that may have been unjustified in the circumstances.

Officer E

291. Based on the evidence presented above, it is my opinion that there is insufficient evidence upon which a reasonable tribunal, properly directed, could find gross misconduct in respect of Officer E for using a level of force that may have been unjustified in the circumstances.

Officer G

292. Based on the evidence presented above, it is my opinion that there is insufficient evidence upon which a reasonable tribunal, properly directed, could find gross misconduct in respect of Officer G for using a level of force that may have been unjustified in the circumstances.

Officer D

293. Based on the evidence presented above, it is my opinion that there is insufficient evidence upon which a reasonable tribunal, properly directed, could find gross misconduct in respect of Officer D for using a level of force that may have been unjustified in the circumstances.

Officer K

294. Based on the evidence presented above, it is my opinion that there is insufficient evidence upon which a reasonable tribunal, properly directed, could find gross misconduct in respect of Officer K for using a level of force that may have been unjustified in the circumstances.

Criminal offences

295. On receipt of my report, the Commission delegate must decide if there is an indication that a criminal offence may have been committed by any person under investigation.

296. If they decide that there is such an indication they must decide whether it is appropriate to refer the matter to the CPS.

297. Having analysed all the evidence, it is my opinion that there is no indication that any person under investigation may have committed a criminal offence.

Appendix 1: The role of the IPCC

The IPCC carries out its own independent investigations into complaints and incidents involving the police, HM Revenue and Customs (HMRC), the National Crime Agency (NCA) and Home Office immigration and enforcement staff when the seriousness or the public interest require it.

We are completely independent of the police and the government. IPCC commissioners by law may never have worked for the police.

All cases are overseen by a Commission delegate, providing strategic direction and scrutinising the investigation.

The investigation

At the outset of an investigation, a lead investigator will be appointed who will be responsible for the day-to-day running of the investigation on behalf of the Commission. This may involve taking witness statements, interviewing subjects to the investigation, analysing CCTV footage, reviewing documents, obtaining forensic and other expert evidence, as well as liaison with the coroner, the Crown Prosecution Service (CPS) and other agencies.

They are supported by a team including other investigators, lawyers, press officers and other specialist staff.

Meaningful updates are provided to families and other stakeholders both inside and outside the IPCC at regular intervals.

Throughout the investigation, a series of reviews and quality checks will take place.

The IPCC investigator often makes early contact with the CPS and are sometimes provided with investigative advice during the course of the investigation, however, we are usually asked by the CPS to keep any such advice confidential.

Investigation reports

Once the investigator has gathered the evidence, they must prepare a report. The report must summarise the evidence and refer to or attach any relevant documents. As notices of investigation have been served in the course of the investigation, the report must also give the investigator's opinion about whether any police officer or member of staff has a case to answer for misconduct.

The report must then be given to the Commission delegate who will decide if a criminal offence may have been committed by any of the subjects of the investigation and whether it is appropriate to refer the case to the CPS for a charging decision.

The Commission delegate will then decide whether to make individual or wider learning recommendations for the police. They also consider whether the actions of

anyone serving with the police were unsatisfactory. If so, they will be dealt with through the police force's unsatisfactory performance procedure (UPP). UPP is handled by the person's line manager and is intended to improve the performance of both the individual and police force.

Misconduct proceedings

The report must be given to the appropriate authority (normally the police force) responsible for the subjects of the investigation. They must then inform the Commission what action they propose to take, in particular whether they will bring misconduct charges in relation to any of the police officers or staff who were subjects of the investigation. If the Commission delegate is unhappy with the appropriate authority's response, the Commission has powers to recommend or ultimately direct it to bring disciplinary or UPP.

Criminal proceedings

If there is an indication that a criminal offence may have been committed by any subject of our investigation the IPCC may refer a subject to the CPS. The CPS will then decide whether to bring a prosecution against any person. If they decide to prosecute, and there is a not guilty plea, there may be a trial. Relevant witnesses identified during our investigation may be asked to attend the court. The court will then establish whether the defendant is guilty beyond all reasonable doubt.

Inquests

Following investigations into deaths, the IPCC's investigation report and supporting documents are usually provided to the coroner. The coroner may then hold an inquest, either alone or with a jury. This hearing is unlike a trial or tribunal. It is a fact finding forum and will not determine criminal or civil liability. A coroner might ask a selection of witnesses to give evidence at the inquest. At the end of the inquest the coroner and/or jury will decide how they think the death occurred based on the evidence they have heard and seen.

Publishing the report

After all criminal proceedings relating to the investigation have concluded, and at a time when the IPCC is satisfied that any other misconduct or inquest proceedings will not be prejudiced by publication, the IPCC may publish its investigation report.

Redactions might be made to the report at this stage to ensure that individuals' personal data is sufficiently protected and occasionally for other reasons.