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IN THE CORONERS COURT IN NORTHERN IRELAND

BEFORE THE CORONER OF NORTHERN IRELAND
MARIA DOUGAN

IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF JAMIE WILSON

Appearances

Mr Philip Henry KC and Ms Rachel Bergin BL appeared on my behalf, instructed by Ms Sophie Lavery and Ms Francine McFarland, Coroners Service for Northern Ireland (CSNI);
Mr David Russell KC and Mr Damian Halleron BL appeared on behalf of the Next of Kin (NOK), instructed by Mr Brendan Hagan, JPH Law;
Ms Fiona Fee KC and Ms Leona Gillen BL appeared on behalf of the Police Service of Northern Ireland (PSNI), instructed by Ms Stephanie McCollum, Crown Solicitors Office (CSO);
Mr David Reid BL appeared on behalf of the Southern Health and Social Care Trust (SHCST) instructed by Ms Catherine McReynolds, Directorate of Legal Services (DLS);
Mr Michael McCartan BL appeared on behalf of Dr Brian Cupples, instructed by Ms Francesca McGlynn, Tughans Solicitors;
Mr Chris Sherrard BL appeared on behalf of Dr Richard Harrison, instructed by Mr Gareth Doran, Donard King Solicitors;
Mr Richard Smyth BL appeared on behalf of Sergeant Greg Stevenson, instructed by Mr Michael May, Edwards & Co Solicitors.

I wish to formally place on record my sincere appreciation to my legal team for their support and dedication, throughout this inquest process, together with the staff from the Coroners Service for Northern Ireland. In addition, I acknowledge and thank the legal representatives acting on behalf of the Properly Interested Persons (PIPs) for their engagement throughout these proceedings.

I further wish to formally recognise the engagement and resilience of the Wilson family. I am grateful for the respect they have shown this inquest process, and I extend my sincere condolences on the loss of Jamie.

Introduction

[1] This inquest investigated the death of Mr Jamie Wilson, born on 29 July 1984 of 75b Drone Hill Road, Corbet, Banbridge, who died on 7 May 2018 in the Intensive Care Unit (ICU) of Craigavon Area Hospital. In the days prior to his collapse on 1 May 2018, the deceased was involved in two interactions involving physical restraint by Police Service of Northern Ireland (PSNI) Officers.

[2] The deceased's death was investigated by the Police Ombudsman for Northern Ireland (PONI), and a file was forwarded to the Director of Public Prosecutions (DPP). In 2022, the Public Prosecution Service directed that there would be no criminal prosecution of any PSNI Officers in relation to the death of the deceased.

[3] This inquest was held in Banbridge Courthouse on 3, 4, 5, 6, 7 and 11 March 2025. During the inquest, I heard oral evidence from 15 witnesses. In addition, I also admitted into evidence a further 23 written witness statements, along with a substantial volume of medical notes, records, reports, video and CCTV footage, pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ('the 1963 Rules'). An exhibits list was compiled during the inquest by my legal team. It is neither necessary nor practicable to rehearse in detail the entirety of the evidence adduced in the course of this inquest. However, I wish to make it clear that I have given full, careful, and conscientious consideration to all of the evidence presented to me, both oral and written, in reaching the conclusions set out herein.

[4] It is my sincere hope that my findings will serve to settle any pre-existing rumours and suspicion by providing an evidence-based account of the circumstances in which the deceased died.

Summary of events

[5] On the evening of 29 April 2018, the deceased had been drinking with his girlfriend in Banbridge. In the early hours of 30 April 2018, police attended following an alleged assault on the deceased's girlfriend. The deceased was arrested and conveyed to Banbridge Custody Suite. During transit, he was reported to have repeatedly struck his head against the window of the vehicle and became aggressive, requiring restraint by police officers. On arrival at custody, further restraint was required following aggression, including the use of handcuffs and leg restraints, before he was placed in a cell.

[6] Later that morning, the deceased was observed lying on the floor of the cell exhibiting unusual movements and incontinence. A Forensic Medical Officer ('FMO') attended, noted he was breathing well and easily roused, and considered

him fit for detention, arranging a later review. The deceased subsequently complained of headache and sensitivity to light and appeared improved on further assessment. He was later interviewed, charged, and released on bail at approximately 15.17 hours on 30 April 2018.

[7] On the evening of 1 May 2018, he was found by his sister and neighbour to be confused, with right-sided weakness and vomiting. He was taken by ambulance to Craigavon Area Hospital, where imaging confirmed a large left-sided cerebral infarct. He was transferred to the Royal Victoria Hospital, where further imaging confirmed a significant stroke, and active intervention was not considered appropriate. The deceased was later returned to Craigavon Area Hospital, where his condition deteriorated. Following confirmation of brainstem death, he died on 7 May 2018.

Scope of the inquest

[8] It is well-established that an inquest is a fact-finding exercise. It does not determine civil or criminal liability. The applicable standard of proof is the civil standard, namely the balance of probabilities.

[9] A provisional scope document was presented to the Properly Interested Persons (PIPs) prior to the inquest commencing. None of the PIPs suggested any additions, deletions or other adjustments. The scope document read as follows:

> " This is a provisional definition of the scope of the inquest proceedings.
>
> 1. This inquest will examine the death of Jamie Wilson.
>
> 2. The inquest proceedings will consider the four matters listed in Rule 15 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, namely:
>
>   (a) the identity of the deceased;
>   (b) the place of death;
>   (c) the time of death; and
>   (d) how the deceased came by his death.
>
> 3. In respect of "how" the deceased came by his death, and in order to allay any rumour or suspicion to the extent appropriate in this case, the Coroner will consider the following:
>
>   i. How he presented while in police custody
>   ii. How he presented in the CAH
>   iii. How he presented in RVH

iv. The treatment he received at each of the above stages, to the extent necessary for the inquest.

However, the purpose of an inquest is not to attribute criminal or civil liability.

4. The Coroner will consider evidence from witnesses, medical notes, PSNI investigation materials, policy materials from the public authorities, the pathology evidence available, and the other potentially relevant material provided to the inquest.

The above definition of scope may be subject to amendment if considered necessary by the Coroner as the inquest progresses."

[10] There was no adjustment of this scope document during the course of the inquest.

[11] I am satisfied that this inquest has addressed all the relevant issues and that, where possible, I have reached a finding in respect of the matters which come within the scope of this inquest.

Review of the evidence

[12] These findings are divided into seven parts:

- **Part 1**: 30 April 2018 – events at 75b Drone Hill Road, Corbet, Banbridge and the Custody Suite in Banbridge PSNI Station;
- **Part 2:** 30 April 2018 – events in the Custody Suite and cell 7 in Banbridge PSNI Station;
- **Part 3**: 1 May 2018 – events at 75b Drone Hill Road, Corbet, Banbridge and Craigavon Area Hospital
- **Part 4**: Expert evidence – Police restraint
- **Part 5:** Expert evidence – Forensic Medical Officers
- **Part 6:** Expert evidence – Pathology
- **Part 7:** Expert evidence – Neurology

<u>Part 1: 30 April 2018 – events at 75b Drone Hill Road, Corbet, Banbridge and the Custody Suite in Banbridge PSNI Station</u>

Lana Shead

[13] Ms Lana Shead, partner of the deceased, gave evidence to the inquest, which was admitted by way of Rule 17. She had known the deceased for seven years and had been in a relationship with him since 2 August 2017. She described it as a happy relationship, and she lived between the deceased's home and her parents' home.

[14] On the afternoon of Sunday 29 April 2018, the deceased and Ms Shead went fishing by the river walk, near Banbridge Leisure Centre. They left around 20.00 / 20.30 hours. Ms Shead stated that she probably had about a bottle and a half of Buckfast by the end of the night, and the deceased had three or four bottles of Buckfast. She claimed that quantity would have been normal for the deceased, as he used to drink six bottles a day before they started going out together. He then cut his intake down to 1 to 2 bottles a day. Ms Shead outlined how the deceased had been drinking Buckfast every day from when he was thirteen years old and that he also consumed drugs for years.

[15] When they left the river, they ran into a male whom they both knew. He offered them a draw of what was supposed to be a cannabis joint, which they took. However, Ms Shead believed that it was "trippy weed", meaning it contained a lot of chemicals, as neither she nor the deceased recalled many events after they took it. The deceased bought a bag of what was supposed to be cannabis from the male.

[16] Ms Shead stated that she did not remember anything after this. Her next memory was waking up in the deceased's house in a pool of her own blood with the deceased hanging over her saying, "I'm going to kill ya". The next thing she remembered was waking up in hospital. She explained her injuries included a split on her head, a swollen face, handprint marks on her neck, bruising and she had broken teeth with some knocked out of place. At around 03.00 hours on Monday 30 April 2018, Ms Shead left the hospital of her own accord and returned to her parents' home. She later returned to the hospital. Her mother told her the deceased had been arrested. Ms Shead tried calling the deceased that evening but there was no reply. Later that night, the deceased texted Ms Shead saying he was sorry and that he did not know what had happened. There was around a gap of twenty minutes between each text and Ms Shead stated that the texts made sense. The last text she received was "I love you girl". A report of Ms Shead's phone indicated confusion in some text messages sent by the deceased at 21.30 hours that night. The following day, Tuesday 1 May 2018, the deceased texted Ms Shead around 17.00 hours or 19.00 hours and Ms Shead stated that the messages did not make any sense.

[17] Ms Shead commented that the deceased told her recently that he had headaches and problems with his vision. He used to sit and grab his chest when it became tight, and he also had pains in his arms. Ms Shead stated that this occurred a few times, but he did not attend the doctor.

Constable Mark Anderson

[18] Constable Mark Anderson gave evidence to the inquest. He was attached to Lurgan Police Station. He was a probationary constable and at the time, had

completed 8 months service. At 01.00 hours on 30 April 2018, he received a radio transmission to respond to a report of an unresponsive female with a suspected head injury at 75b Drone Hill Road, Banbridge. He was in a three-person response crew in Banbridge. Constable Morrison was the driver, and Constable Anderson was the lead observer, with Constable Heslip an extra member of the crew. They arrived at the property within minutes. The female, Lana Shead, was lying on the floor in the recovery position. There was blood around her head and on the floor beside her. Constable Anderson observed that Ms Shead's front teeth were loose and damaged and she had a laceration to the top of her head. Constable Anderson and Constable Heslip attended to Ms Shead.

[19] A short time later, a second callsign with Constable Mackin and Constable Montgomery arrived. They dealt with the deceased and handcuffs were placed on him. Paramedics from Northern Ireland Ambulance Service (NIAS) attended and treated Ms Shead's injuries before conveying her to Craigavon Area Hospital.

[20] Constable Anderson told the inquest that Ms Shead reported that the injuries to her face were caused by her partner, the deceased, punching her. She stated that the deceased had threatened to kill her and then assaulted her.

[21] At 01.50 hours, Constable Anderson arrested the deceased on suspicion of assault occasioning actual bodily harm and making threats to kill. The deceased was already handcuffed, and he co-operated getting into the police car for transit to Banbridge Custody Suite. Constable Anderson stated that this journey would normally take between five and ten minutes.

[22] Constable Anderson was the front seat passenger, while Constable Morrison was the driver and Constable Montgomery was in the back seat with the deceased, who was sitting directly behind Constable Anderson. Constable Anderson told the inquest that Constable Montgomery was swapped with Constable Heslip for a number of reasons including the fact the deceased was male, his physical demeanour and the information that he had allegedly violently assaulted a female.

[23] Constable Anderson described how, within the first minute or so of the journey, the deceased began making strange noises, like groaning, and he put his head down towards his knees. He then started hitting his head off the window of the police vehicle. Constable Anderson asked Constable Montgomery what was going on as it was dark and he could not see for himself. With the change in behaviour the police vehicle stopped, and Constable Anderson got out and opened the rear passenger door beside the deceased. He then described how there was "some sort of commotion going on" and at this point Constable Anderson put two hands on the deceased to try and bring him up back into his seat. He did not see the deceased elbow Constable Montgomery in the chest and grab his arm. He commented that he did not recall Constable Montgomery using any force on the deceased. Constable Heslip arrived and her Body Worn Video was played to the inquest.

[24] Constable Mackin from the second crew arrived and took Constable Anderson's place beside the deceased. Constable Anderson explained how Constable Mackin tried to get hands on the deceased and then Constable Mackin kicked towards the deceased who was still sitting in the police car. Constable Anderson did not record this kick incident in his statement or notebook prior to giving evidence.

[25] Events calmed down and the deceased was heard saying, "I just wanted to see what yous have and yous have nothing." Constable Montgomery informed Constable Anderson that the deceased elbowed him in the chest. At 01.57 hours, Constable Anderson further arrested the deceased for the assault of a police officer. Constable Anderson told the inquest that for the rest of the journey the deceased remained calm.

[26] On arrival at the custody suite, Constable Anderson, as arresting officer, spoke to the Custody Sergeant, Sergeant Greg Stevenson, at the custody hatch. CCTV footage of these events was played throughout the inquest. According to the custody record, the time of arrival was 02.05 hours. Constable Anderson accepted that he did not inform Sergeant Stevenson about the deceased banging his head against the car window as he "did not deem it to be that important" and accepted that he could have.

[27] The deceased was led from the police vehicle to the custody hatch and the handcuffs were removed. Detention was authorised at 02.20 hours. Review of the CCTV footage inside the custody suite, showed that when Sergeant Stevenson informed the deceased that he was being detained for offences including an assault on police, the deceased adopted what was described in evidence as a boxing stance. He faced Constable Mackin, who was standing on the right-hand side of the hatch and enounced words to the effect, "if you wanna be assaulted, if I'm gonna actually be done by the police", and then with his hands open, he lunged at Constable Mackin and pushed him. Constable Mackin stepped back and Constable Morrison moved towards the deceased and took his hands. The deceased was then restrained by five officers and a Civilian Detention Officer (CDO) and brought to the floor of the corridor beside the custody hatch. Constable Anderson was involved in this restraint and described the deceased as going "from very calm to very aggressive".

[28] Constable Anderson told the inquest that Sergeant Stevenson, as custody officer, took the lead and was very calm, professional and directed how the restraint was going to take place, as he had primary responsibility for everyone. Two sets of handcuffs were placed on the deceased, linked together, as well as leg restraints around his knees and around his calves. The deceased was lying prone on the corridor and then lifted, in that position, and carried to cell 7. Constable Anderson believed he was one of the officers who carried the deceased. The deceased was placed on a blue mattress in the cell in the prone position. Constable Anderson stayed in the cell for a short time and then left to complete paperwork. From 05.45 hours to 06.30 hours, he conducted observations on the deceased using the CCTV screens located in the custody office.

[29] In relation to the restraint, Constable Anderson told the inquest that he had received training in the national decision-making model which requires information gathering and risk assessments before actions are taken. He stated they had decided that the best course of action was physical restraint, to get the deceased to the ground as safely and as quickly as possible and then apply restraints.

Constable Leanne Heslip

[30] Constable Leanne Heslip gave evidence to the inquest, which was admitted by way of Rule 17. She described how she and Constables Anderson and Morrison were met by the deceased when they arrived at his home. Her colleagues spoke with him and upon entering, she saw a female on the floor and her initial thought was that she was dead as she was not moving. She stated that she helped her as best she could, but she was screaming a continuous scream.

[31] When Ms Shead was taken to hospital, Constable Heslip swapped with Constable Montgomery, and she was in the support vehicle during the transit. The vehicle containing the deceased suddenly stopped. She got out of the support vehicle and looked through the rear passenger door, where the deceased was sitting. She described how she saw the deceased swinging his left elbow in an aggressive and forceful way. Constable Heslip believed that the deceased was actually hitting someone on his right - Constable Montgomery. She could hear police asking him to calm down but he continued to swing. She recalled the deceased laughing after a few moments and then telling them to go on. She stated that it all stopped within moments and they continued onto Banbridge Custody Suite.

[32] On arrival at the custody suite, the deceased was compliant, standing at the hatch. As soon as Sergeant Stevenson mentioned the offence of assault on police, the deceased reacted and swung around to his right, about 90 degrees, in the direction of police officers, squaring up to them. Constable Heslip took a step back and recalled one of the police officers saying "Jamie, calm yourself down". A struggle and restraint then took place.

[33] During the restraint the deceased was brought to the floor. Constable Heslip stated that she did not see any of the officers, act unreasonably or use excessive force on him. She added that the force used was just to restrain him, which was necessary in the circumstances. Constables Montgomery, Anderson, Mackin, Morrison, and Sergeant Stevenson and Civilian Detention Officer ('CDO') McNiece were involved.

[34] Constable Heslip outlined that her involvement in the restraint was leaning on the deceased's leg in order to stop him kicking out. Constable Montgomery asked her for limb restraints, which she gave to him. She stated that she was only holding his legs for a matter of seconds as she had to get the limb restraints out of her belt.

[35] The deceased was then carried to a cell at the end of the custody suite. She recalled one of the officers telling the deceased that once he calmed down, the restraints would be taken off. She stated that the deceased seemed to calm down quite quickly.

[36] Between 04.50 hours and 06.35 hours, Constable Heslip monitored the deceased from the CCTV screens in the custody office.

[37] Constable Heslip explained that during her dealings with the deceased, she formed the opinion that he was under the influence of either drink or drugs. He had told her earlier that he had been drinking at his girlfriend's parents' house. She added that his behaviour was volatile and unpredictable and that she just did not know what would happen next with him.

Constable John Paul Morrison

[38] Constable John Paul Morrison gave evidence to the inquest. At the time, he had been a serving officer for nine and a half years. At approximately 01.00 hours, he, along with Constables Anderson and Heslip were tasked to 75b Drone Hill Road, Corbet in relation to the report of a female struck over the head with a dumbbell bar. Constable Morrison was the driver.

[39] On arrival, the deceased met them outside and led them inside to the living room area. Constable Morrison noted that the deceased was naked from the waist up, he could smell alcohol from the deceased's breath, and his speech was a bit slurred, but he was not aggressive. Constable Morrison described him as very cooperative at that time.

[40] Constable Morrison observed Ms Shead, lying on the floor in the recovery position, not moving or making any noise. There was a large amount of blood to her head and on the floor beside her.

[41] Constables Anderson and Heslip spoke to Ms Shead who was complaining of injuries to her mouth and the top of her head. Constable Morrison spoke with the deceased who informed him that Ms Shead had walked into a dumbbell bar that he had been using. He pointed to a dumbbell bar sitting on the kitchen worktop. At 01.25 hours, Constable Morrison seized this bar. On their arrival, Constables Montgomery and Mackin spoke with the deceased. Paramedics arrived a short time later and conveyed Ms Shead to Craigavon Area Hospital. Prior to leaving, Ms Shead alleged that the deceased told her that he was going to kill her and had also struck her mouth. She could not offer any further information on how she sustained the head injury, stating she could not remember.

[42] Constable Morrison's Body Worn Video of these events was played during the inquest.

[43] At 01.50 hours, Constable Morrison was present when Constable Anderson arrested the deceased on suspicion of assault occasioning actual bodily harm and threats to kill.

[44] While on route to Banbridge Custody Suite, Constable Morrison, who was the driver of the vehicle, described how the deceased became aggressive and started to bang his head off the window of the police vehicle, as he could hear the thudding.

He recalled Constable Montgomery telling him to stop, or words to that effect. He then stopped the vehicle and got out and walked around to the rear passenger door. Constable Montgomery was still inside the vehicle. Constable Mackin from the support vehicle came to assist. Constable Morrison stood behind Constable Mackin. Constable Morrison described how the deceased lashed out at police officers, meaning arms and legs were moving, but he did not see him make physical contact in an aggressive way with a police officer. Constable Morrison described the deceased as roaring and shouting, using words to the effect of, "Is that all yous have got," and laughing. Constable Morrison recalled stating, "Jamie, can you calm down?" and eventually he did. Constable Morrison told the inquest that he did not see Constable Mackin kick out at the deceased. Constable Morrison moved the passenger seat back to restrict the deceased's legs. The deceased calmed down and the decision was made to carry on to Banbridge Custody Suite.

[45] While at the rear of the custody suite, the deceased repeatedly stated to Constable Morrison that Ms Shead had jumped from a seated position into the dumbbell bar before then falling on her mouth. Constable Morrison explained that there were no signs of aggression from the deceased, he just kept repeating the same thing over and over. He was then taken into the custody suite and Constable Morrison followed in and stood at the hatch.

[46] Constable Morrison told the inquest that once the deceased heard the offence of assaulting a police officer, he became extremely aggressive and said something along the lines of, "If I'm being done for assault on police, I may as well do what I'm getting charged for." He held out his arms in front of him in a fighting stance. Constable Morrison told the inquest that after the deceased lunged towards Constable Mackin, he walked towards him with his hands open and told him to calm down. He initially had control of the deceased's wrists, and the deceased pulled his arms away and walked backwards as Constable Morrison moved towards him. Constable Morrison then held the deceased around his head in a headlock position. He denied he applied pressure to the deceased's neck and stated that he held him around his jawline and that it all happened very quickly. He described how this was an attempt to get control of the deceased. He agreed that this was not a restraint technique that he was trained in and that, in fact he was trained in the dangers of using restraint around the neck or head. Constable Morrison then described how other officers brought the deceased to the ground which he described as "a pile on" by the officers. The deceased was handcuffed in the rear stack position using two sets of handcuffs and his legs placed in limb restraints.

[47] Constable Morrison expressed how he had no concerns about the length of time the deceased was in the corridor in the prone position, as there was no change in his breathing and he was continuing to communicate. Constable Morrison conducted close observations of the deceased whilst he was in the cell.

Constable Nathan Montgomery

[48] Constable Nathan Montgomery gave evidence to the inquest. He was attached to Lurgan Police Station and at the time had been an officer for 15 months. At approximately 01.15 hours, he arrived at the deceased's home as the second callsign with Constable Mackin.

[49] Constable Montgomery spoke to the deceased outside the property. The deceased told him that he had been doing dumbbell curls when his girlfriend, Ms Shead, got up and hit her head on the dumbbell in his hand. He described the deceased as appearing quite volatile and quite agitated and so the majority of the conversation was trying to calm him down, explain what police were there for and explain that, based on the fact that Ms Shead had a significant head injury and it was alleged that the deceased had assaulted her, it was likely that he was going to be arrested. Constable Montgomery clarified that whilst the deceased did not display any overt aggression to him or Constable Mackin, he stated that from his experience, it appeared to him that the deceased was on the edge of tipping over to the point of aggression. He appeared very frustrated and whenever he realised that he would likely be arrested, "its seemed to raise his tensions".

[50] At approximately 01.30 hours, Constable Montgomery applied handcuffs to the deceased, in the front stack position, which the deceased complied with. He was then arrested by Constable Anderson and placed in the rear of the police vehicle. Constable Montgomery sat in the rear with the deceased for the journey to custody, in place of Constable Heslip, as he had built up a rapport from speaking to him and he had a larger body weight compared to Constable Heslip, "in case something did go wrong".

[51] In transit, at approximately 01.55 hours, Constable Montgomery described how the deceased began to bang his head against the window of the vehicle and he then appeared to place his head low down and wedge it between the door cover and the front passenger seat. At this time, he began to make a growling sound.

[52] Constable Montgomery explained that he instructed the deceased to sit back by saying something along the lines of "Jamie sit up" or "can you sit back?". He put his hand on the deceased's shoulder, "not in a forceful way, just as a sort of guide, to try and get him to sit back and then it's at that stage that he flies back and then throws the elbow out towards me" and struck Constable Montgomery in the chest. Constable Montgomery was wearing a bullet proof vest, so he was not injured but did feel the force of the impact. At this point, Constable Montgomery described how the deceased grabbed hold of one of his forearms, he believed his right forearm, with both hands, squeezed and pulled it downward and towards himself. The deceased pulled him over to the left on top of him, so Constable Montgomery's left ear was in front of the deceased's face and his body was over the top of his lap. The deceased had hold of his arm for approximately one minute as Constable Montgomery attempted to loosen his grip by applying a pressure point with his left thumb behind the deceased's right ear, at least twice, which he stated had no effect. Constable

Montgomery then, with his left hand, and a closed fist, started striking the deceased along the right side of his abdomen, between his armpit and his hip. He believed he may have done this between five and ten times. He stated that this had no effect on the deceased.

[53] Constable Mackin then opened the deceased's door, and Constable Montgomery planted his right foot flat in the footwell on the right-hand side of the vehicle and from there, he used his left knee to strike into the right side of the deceased's abdomen, around five times. The deceased was still holding on to Constable Montgomery's right forearm at this stage. Constable Montogomery recalled at least one kick coming from Constable Mackin. He stated that the knee strikes appeared to be completely ineffective, and then, the deceased let go of his forearm, of his own volition, and then started laughing and made a comment along the lines of, "I just wanted to see what yous had, lads, taking me into custody". Constable Montgomery got out of the vehicle for a short time and the deceased was further arrested by Constable Anderson for assaulting a police officer. They then resumed the journey to Banbridge Custody Suite without incident.

[54] Constable Montgomery accepted that he did not inform the custody sergeant of the deceased's banging his head on the window or his application of pressure points or use of his fist or knee on the deceased's abdomen.

[55] When they arrived in Banbridge Custody Suite, Constable Montgomery got a glass of water behind the custody desk. He then heard what he described as a kafuffle, and he came out and the deceased was in the process of being restrained. He then got involved. Sergeant Stevenson was giving directions. Constable Montgomery restrained the deceased's feet and applied limb restraints to the deceased's ankles. In relation to the deceased lying prone, Constable Montgomery explained that he was aware of the risk of positional asphyxia and other risk factors including alcohol, drugs, and whether the person is handcuffed. He accepted that all these factors were present in the deceased's case, and he stated it was something they were actively monitoring. He claimed that the deceased was engaging in some conversations throughout, so it did not appear to them that he was having any difficulties.

[56] Constable Montgomery was involved in lifting the deceased into the cell and he and Constable Mackin remained there for some time conducting constant observations with the cell door open. During that period, the deceased was face down with two sets of restraints, one above his knee and one towards his ankles and had double handcuffs applied behind his back. On the instructions of Sergeant Stevenson, the level of restraint was gradually reduced in increments, to ensure they had compliance at each stage. The custody record noted that at 02.46 hours the deceased was moved to a seated position. At 02.59 hours the knee limb restraints were removed, with bottom leg restraints removed at 03.14 hours. At 04.26 hours, handcuffs were removed. It was explained that these actions may have been slightly earlier than recorded in the custody log as Sergeant Stevenson may not have recorded the information immediately due to other tasks.

Constable Glen Mackin

[57] Constable Glen Mackin gave evidence to the inquest. At this time, he had been an officer for around nine years. Constable Mackin was in a support crew along with Constable Montgomery. When they arrived at the deceased's home, they spoke with the deceased outside for an extended period of time to allow the paramedics and other officers to deal with Ms Shead. Constable Mackin described how they were trying to keep the deceased calm. He stated that due to his size and his muscular build and the background to the call, they did not know if he presented a danger to officers or anyone else at the scene, so they wanted to keep him as calm as possible. They discussed his version of events and explained that handcuffs would have to be placed on him, and he would have to attend the police station. Constable Mackin told the inquest that he was at no stage ever comfortable in the deceased's presence. He stated that "*he presented a danger at all times in my opinion*".

[58] When it came time for the deceased to be transported to Banbridge Custody Suite, Constable Mackin was the driver of the support vehicle, with Constable Heslip in the passenger seat.

[59] After a matter of seconds, the police vehicle in front stopped on the road. Constable Mackin did not recall any radio transmission about what was going on. He recalled Constable Anderson exiting the police car in front, and he followed suit, as he had drawn the conclusion that there was something happening in the rear of that vehicle.

[60] Constable Mackin then went over to the rear passenger side door, where Constable Anderson was. He stated that he took his place because Constable Anderson had less years of service and he was physically smaller. Constable Mackin was then the officer closest to the deceased outside the vehicle. Constable Mackin told the inquest that he believed the deceased had Constable Montgomery's right forearm in "a vice like grip" with both hands.

[61] Constable Mackin leaned into the vehicle and tried to prise the deceased's hands off Constable Montgomery. He stated that he took the deceased's fingers and tried to prise them off his colleague's arm, to "lever his grip to try and release the grip on Constable Montgomery". He described the deceased as "very, very strong". He recalled Constable Montgomery was shouting for him to let go. He could not recall whether any warnings about the use of force were given but stated that words like "stop what you're doing or police will use force" "probably wasn't" said.

[62] During this time, Constable Mackin saw Constable Montgomery use his open palm and put two to three strikes to the deceased's right side rib cage area. He stated that he did not see anything else such as pressure points or blows to the head, face or eye area, being applied at that time.

[63] In Constable Heslip's Body Worn Video, Constable Mackin is observed stepping back from the deceased and then making a kicking or stamping motion towards the deceased seated in the back of the vehicle. Constable Mackin was asked

to explain his actions. He stated that as he had been prising the deceased's fingers from his colleague's arm, the deceased grabbed at him. He stated that he immediately stepped back. He revealed that his fear was that the deceased was just going to follow through and come straight out of the vehicle, so, with the flat of his foot, he kicked the deceased's hands back, which were down at his waist level. Constable Mackin explained that he "kicked down towards his hands, towards the footwell of the vehicle to keep his hands away because I suppose in that moment, I didn't want him getting the same sort of grip that he had on Constable Montgomery" and "I wanted him kept in the vehicle so we could control him at least in that area". When asked whether he received any police training to perform that kind of action, Constable Mackin replied "Not directly. I suppose it is an option if you're feeling threatened. At that time, I did feel threatened, but I suppose, there's many options open to you in relation to personal protection but no, I don't believe it's formally taught that that's how you should deal with a situation." When the footage was put to Constable Mackin during inquest, he accepted that, in fact, he kicked at the deceased's waist height rather than into the footwell of the vehicle.

[64] Constable Mackin stated that he did not recall much in the way of contact with the kick and the deceased "stopped any aggression and just laughed about it." He did not observe any injuries on the deceased. The incident then dissipated and they continued to the custody suite.

[65] On arrival in Banbridge Custody Suite, Constable Anderson, the arresting officer, went in and spoke to the custody sergeant, Sergeant Stevenson. He explained the circumstances, then detention was authorised and then the deceased was brought into the custody suite and up to the hatch. Constable Mackin was present in and around the area of the hatch whenever this took place. There was a conversation between Sergeant Stevenson and the deceased during the course of the booking process. Towards the end of that conversation there was mention of assault on police and then things changed.

[66] Constable Mackin stated that the deceased said something to the effect of "I'll show you assault on police", and then he lunged forward towards Constable Mackin who was standing beside the door to the custody office. The deceased pushed Constable Mackin in the chest area with force, with the open palm of his hands, and Constable Mackin stepped back. Constable Mackin's earpiece was knocked out. The deceased then stood in a boxer's stance with fists clenched. Other police then were involved in restraining the deceased on the floor.

[67] Constable Mackin explained that Sergeant Stevenson directed officers in placing restraints on the deceased and he kept everyone calm. Constable Mackin restrained the deceased's upper body and his head. Constable Mackin accompanied the deceased to the cell where he conducted constant observations with Constable Morrison. The deceased was in the prone position for 11 minutes and then moved onto his backside. Constable Mackin told the inquest that he did not use any force than was absolutely necessary and he did not observe any other officer on that occasion using unnecessary force.

Part 2: 30 April 2018 – events in the Custody Suite and cell 7 in Banbridge PSNI Station

Sergeant Greg Stevenson

[68] Sergeant Greg Stevenson gave evidence to the inquest. At the time, he had been a custody sergeant since 2006. On 30 April 2018, Sergeant Stevenson was the custody sergeant in Banbridge Custody Suite, working a 12-hour shift. He was due to handover to Sergeant Grattan at 08.00 hours. He explained that there were seven cells and two CDOs to assist the custody sergeant. They had the ability to contact a Forensic Medical Officer from the 24-hour rota should they require a medical review and in case of emergencies, they could call for an ambulance. On the evening of 29 April 2018, CDO Hickey had to leave early and so CDO McNiece was the only CDO assisting for the remainder of the shift.

[69] According to the deceased's custody record, the deceased arrived at Banbridge Custody Suite at 02.05 hours. Constable Anderson spoke with Sergeant Stevenson at the custody hatch. Sergeant Stevenson did not recall being informed that the deceased banged his head off the vehicle window. He stated that this is information he should have been told during the booking process because of the risk of a head injury. Equally, he was not informed of pressure points being used on the deceased's neck or strikes to the abdomen or a kick by officers. He stated this was all information he should have been told to assist him in assessing risk.

[70] The CCTV footage showed the deceased being brought in to the custody suite and the booking process commencing. Sergeant Stevenson agreed that the deceased's handcuffs could be removed. The deceased then moved toward Constable Mackin, and other officers surrounded the deceased. Sergeant Stevenson and CDO McNiece then came out of the custody office. At the time, Sergeant Stevenson thought that the deceased had showed aggression and struck out towards Constable Mackin. A struggle ensued and the deceased was restrained and brought to the floor of the custody suite corridor.

[71] Sergeant Stevenson took an active role in the use of force and restraint, and he stated that he was never advised to stand and coordinate "and do nothing". He revealed that he regretted allowing the handcuffs to be removed as this may have prevented events escalating in the way they did. He commented that the situation needed to be taken under control and so he wanted the deceased on the ground so handcuffs could be applied. Sergeant Stevenson then directed the officers what to do and he could be heard on the footage saying words to the effect of "take him to the ground".

[72] In relation to the amount of force applied on the deceased, Sergeant Stevenson explained that it was manipulating, pushing, pulling and trying to get the deceased in a position where his palms were out towards his back in order to get the handcuffs on. Two sets of handcuffs joined together were place on the deceased's wrists behind his back which Sergeant Stevenson said, "just affords somebody of

Jamie's build that wee bit more comfort". Leg restraints, one set around the upper knee area and the other towards the ankles, were placed on the deceased.

[73] After 4 minutes of the deceased lying prone, Sergeant Stevenson told all present that they would allow the deceased a chance to breathe. His consideration, at this time, was that the staff were still at risk and that the situation needed to settle down and also, he need a moment to catch his breath, and this time allowed him to look at the situation and formulate next steps.

[74] In relation to whether the deceased's vital signs such as his airway were checked, Sergeant Stevenson stated that there were a lot of people around the deceased. When asked why he did not ask for an FMO review at this stage, as Dr Cupples was nearby, he replied that did not want him in the middle of the situation. He stated that he was aware of the risks of positional asphyxia, and at that stage, he was satisfied the deceased was being watched and any deterioration would be brought to his attention. He did accept that "on looking at the CCTV now it's longer than I would like". He was satisfied he was performing the role of safety officer, and the deceased was being observed and there was some feedback from him during that time. Sergeant Stevenson stated clearly that he thought the duration of this restraint was appropriate.

[75] CCTV footage of cell 7 showed Sergeant Stevenson putting two blue mats on the floor in the middle of the cell. He told the inquest that he had decided that they would carry the deceased to the cell and the mats were for his comfort.

[76] The deceased was then lifted by officers and placed on a blue mat in cell 7 in the prone position for approximately 11 minutes. Sergeant Stevenson was involved in this. The deceased was under constant observations by officers in the cell. In relation to the cell extraction technique, a rapid process, where restraints are removed and officers then leave the cell, Sergeant Stevenson stated that, at that stage, there was no way he was leaving the cell and closing the door as the deceased was big, aggressive and unpredictable and he did not want to put any of his staff at risk of going back in to try and physically restrain him again. Also, the cell did not have a toilet and there would potentially be difficulties later trying to accede to a request.

[77] Sergeant Stevenson believed the use of restraints was necessary, reasonable and proportionate at the time. When asked about the length of time the deceased was left in the prone position in the cell, with five officers in attendance, he stated that this was as a result of his perception of the risk that faced the officers in the cell. He accepted that it was "a bit longer than I would like".

[78] Sergeant Stevenson returned to the custody office and completed entries in the custody record, including at 02.40 hours recording that the deceased was on level 4 close proximity observations and an FMO review was necessary. An entry at 02.48 hours recorded that the FMO was to review at 09.00 hours, which Dr Cupples advised on the PACE 15 Form. Sergeant Stevenson explained that he did not request

an FMO review after the deceased calmed down in his cell as he "assessed a continued risk that Jamie might become aggressive again".

[79] At 02.59 hours, the knee limb restraints were removed, and the deceased sat upright on the mat handcuffed to the rear. At 03.14 hours, the bottom leg restraints were removed and at 04.26 hours, the handcuffs were removed.

[80] At 04.28 hours, the deceased's observations were reduced to level 3 – constant supervision, meaning observations conducted at the cell door or on CCTV screens. At 06.44 hours, observations changed to level 2 – intermittent observation every 30 minutes.

[81] Around 07.00 hours, CDO McNiece informed Sergeants Stevenson and Grattan that the deceased was moving strangely on the floor, as if he was trying to get back up on the bed. They all attended the deceased's cell. CCTV footage captured outside the deceased's cell was played during the inquest. After standing outside for approximately one minute and seventeen seconds, Sergeant Stevenson then opened the cell door and said, "What about you Jamie?" and "what's up with you son?" and "are you alright?". He then entered the cell with CDO McNiece. The deceased was lying on his back and had been incontinent of urine. The deceased made no reply. They then left the cell and Sergeant Stevenson stated, "that's definitely the doctor back, I'll have a chat to him". Sergeant Stevenson was heard asking Constable Anderson to assemble a crew in case the deceased needed to be transferred to hospital. He explained to the inquest that he was of the view that the FMO would make that decision, but he was trying to be prepared. He outlined how it was common occurrence for detained persons to have been intoxicated or suffering from withdrawal from alcohol and drugs and be incontinent of urine, and that their medical treatment was the decision of the FMO.

[82] Sergeant Stevenson told the inquest that he did not put the deceased's movements on the floor down "to a fit at that time" but he took the decision to seek advice from an FMO. He believed that CDO McNiece told him he assisted the deceased back on to the bed which he accepted was "an indication that he's [the deceased] suffering and he's in trouble". Sergeant Stevenson went back down to the cell with CDO McNiece who expressed concern about the deceased. Sergeant Stevenson replied, "I think he is play acting".

[83] Sergeant Stevenson told the inquest that upon viewing the CCTV footage, he was "not intent enough" with the deceased in the cell and accepted that he was not sufficiently concerned for his welfare and health. He accepted that during his subsequent one minute seventeen seconds of observations of the deceased from the cell door, the deceased was having difficulties on one side of his body and that it was a medical emergency. He stated that he should not have removed him from constant observations at 06.44 hours and should have considered all the information available to him and called an ambulance.

Sergeant Sharon Grattan

[84] Sergeant Sharon Grattan gave evidence to the inquest. At the time, she had been a custody sergeant for around five to six years. At approximately 06.50 hours on 30 April 2018, she arrived at Banbridge Police Station to start duty as Custody Sergeant at 08.00 hours. She was taking over from Sergeant Stevenson. She explained that as custody sergeant she was in charge of the custody suite and responsible for all the individuals detained therein. She stated that cell 7 was the largest cell. Within the custody office there were two screens which showed footage of each cell. If a detained person was on level 4 constant observations close proximity, the door of the cell would be open and an officer or CDO would be present at the door. If a detained person was on level 4 constant observations via CCTV, they could be observed on screens within the custody office. She explained that level 1 was general observations was the lowest level.

[85] The 30 April 2018 was a training day, and Sergeant Moore was shadowing Sergeant Grattan. Sergeant Stevenson briefed her in relation to the deceased and told her that when he had come into custody, he had to be restrained by several officers. She stated that she was not told about the incident in the police vehicle and officers having to use force.

[86] At some time just after 07.00 hours, CDO McNeice had been observing the deceased's cell on the CCTV. She believed that the deceased had just come off constant observations at this stage. CDO McNiece told her that the deceased had just come off the bed. The deceased was moving strangely on the floor as if trying to get back on the bed. Sergeant Grattan saw him moving strangely on the screen.

[87] At around 07.04 hours, Sergeant Grattan, Sergeant Stevenson and CDO McNiece proceeded to the deceased's cell door. Sergeant Stevenson and CDO McNiece looked at the deceased through the cell door window. A conversation then took place between the three of them. At this time, Sergeant Grattan asked them if the deceased was "absolutely stocious". She also mentioned a previous incident when she dealt with a detained person who had not been on drugs and had been incontinent of urine and Dr Cupples had told her that it could have been because they were either unconscious or had taken a fit. CDO McNiece replied "that's drug behaviour that like".

[88] When asked whether she thought that the deceased should have been taken to hospital at that time as a fit could potentially be a serious medical emergency, Sergeant Grattan replied "not at that stage" as she believed it was appropriate to get direction from the FMO. She added that had the FMO advised on the phone that he should go straight to hospital, that's what they would have done.

[89] Sergeant Grattan went to the custody hatch and at 07.08 hours made a telephone call to Dr Harrison FMO and explained that the deceased had come off the bed, had been incontinent of urine and was moving about strangely. Dr Harrison advised he would come down to the station.

[90] At 07.32 hours, Sergeant Grattan made an entry in the custody record and placed the deceased on Level 3 - constant observations CCTV. She stated she did this because of the deceased's presentation.

[91] Shortly after 08.00 hours, Sergeant Grattan went to the deceased's cell and spoke with him. She explained that she wanted to ensure that she had the full information to brief Dr Harrison when he attended. She asked the deceased if he had any underlying medical issues and asked him if he was epileptic. The deceased told Sergeant Grattan that he was, but he said that he was not taking any medication for it. Sergeant Grattan described how the deceased seemed half asleep, but he was answering her questions. She told the inquest that she "was not concerned in relation to his responses or his level of alertness at that stage". She added "this would be quite a normal conversation to have with somebody in a custody suite early in the morning who has been in from the night before with potential alcohol or drugs in their system. His alertness did not cause me concern at that stage".

[92] Dr Harrison arrived and Sergeant Grattan briefed him in the custody office and explained that the deceased had slid off the bed, how he was moving strangely on the floor and that he had been incontinent of urine. She also told Dr Harrison about the deceased saying that he had epilepsy although he was not taking medication.

[93] Dr Harrison then went to assess the deceased in the cell. Following this, Dr Harrison informed Sergeant Grattan that the deceased was not fit for interview, and that he should be kept on constant observations. Dr Harrison advised that there was no need for the deceased to go to hospital. Dr Harrison said that he would return later at 11.00 hours to review him. Sergeant Grattan did not recall expressing concern or an opinion in relation to the deceased needing to go to the hospital.

[94] At approximately 08.49 hours, Sergeant Grattan recorded in the custody record that the deceased was complaining of a sore head and irritation at bright lights. Accordingly, she made a further call to Dr Harrison, and he stated that he would review him as scheduled at 11.00 hours. When asked whether she should have phoned an ambulance for the deceased at that stage, Sergeant Grattan replied "I'm not, as you are aware, medically trained and we rely very heavily on our forensic medical officers and take their advice and take their lead on all things medical".

[95] At approximately 11.10 hours, Dr Harrison attended the deceased, and he was deemed not fit for interview until 13.00 hours.

[96] At 13.38 hours, Sergeant Grattan made an entry in the custody record recording that the deceased was fit and alert and no longer required constant observations and was placed on level 2 - intermittent observations and close CCTV monitoring.

[97] Shortly after this, the deceased consulted with his solicitor and was then interviewed by police. The deceased was charged and granted police bail. He then left the station.

[98] In her later dealings with the deceased in the custody suite, the deceased confirmed to Sergeant Grattan that he was not epileptic.

Stuart McNiece

[99] Mr Stuart McNiece, Civilian Detention Officer, gave evidence to the inquest. He explained that he started as a CDO in 2012 and was based in Banbridge Police Station. At the beginning of his career, he underwent 6- or 7-weeks training in Garnerville and then underwent refresher Personal Safety Program ('PSP') training annually.

[100] CDO McNiece was in the custody office when the deceased was brought in to the custody suite. He heard noise and immediately left the office to assist the officers. He described the deceased as quite "*a strong fella*" so it took quite a few people to restrain him. He restrained the deceased on his left arm. He stated that he used a proportionate amount of restraint as there were a number of officers involved. He recalled it was a struggle to get the deceased to release one of his arms, which was under his body to place handcuffs on him.

[101] CDO McNiece told the inquest that he had worked with Sergeant Stevenson for around six years and that Sergeant Stevenson took the lead in the restraint. CDO McNiece conducted observations on the deceased whilst he was in the cell. He stated that he had no concerns about the deceased whilst he was lying prone on the mat. He could not recall whether there were any instructions about deescalation. He stated that CDOs are trained in cell extraction techniques but that was something which would be carried out by response officers in Banbridge but was not carried out on a daily basis. He confirmed that he had conducted cell extractions with Sergeant Stevenson in the past.

[102] CDO McNiece's first entry in the deceased's custody record was at 04.01 hours "Visit – Dp awake – all in order – Dp on constant obs". At 04.23 hours, CDO McNiece placed bedding in the cell and at 04.26 an entry indicated the deceased had settled and cuffs were removed and he remained on constant observations by officers observing the CCTV cameras in the custody office. At this stage, the deceased remained under level 3 constant observations. At 04.59 hours, CDO McNiece recorded "Visit - DP awake - all in order" and made a similar entry at 05.28 hours. At 06.05 hours he recorded, "Visit - appears asleep - all in order." An identical entry was made at 06.34 hours. During those 30-minute checks CDO McNiece confirmed he was looking through the cell door and not interacting with the deceased. At 06.44 hours, observations were changed by Sergeant Stevenson to Level 2 – intermittent observations.

[103] Around 06.50 hours, CCTV footage from inside the deceased's cell showed the deceased lying on the bed, covered by a blanket, breathing very loudly. The

deceased's body under the blanket appeared to make involuntary movements, and his legs, not underneath the blanket, were also moving.

[104] At 07.01 hours, CDO McNiece recorded "Visit – appears asleep – all in order". He told the inquest that he then returned to the custody office and observed the CCTV and saw that the deceased was lying on the floor of the cell. CCTV footage showed that four minutes later, CDO McNiece and Sergeants Grattan and Stevenson attended the door of the cell.

[105] CDO McNiece denied that he saw the deceased on the floor when he looked in the cell at 07.01. It was put to him that when the footage of inside the cell was compared with that outside, he could be viewed in the glass of the deceased's cell door, which coincided almost to the second with the deceased falling off the bed. He replied, "I didn't see him falling off the bed when I looked in. The first time I saw was when I saw him on the CCTV when I got back into the office." When it was put to him, that if his timings were correct, then when he did look in the cell, he must have observed the deceased's fit, he replied, "I'm not sure".

[106] After Sergeants Grattan and Stevenson and CDO McNiece left the cell, at 07.04 hours, CDO McNiece returned a short time later, entered the cell and asked the deceased if he was okay and then assisted him onto the bed.

Dr Brian Cupples

[107] Dr Brian Cupples, GP and Forensic Medical Officer, gave evidence to the inquest. He was an FMO for 35 years, and a general practice practitioner for 38 or 39 years.

[108] Dr Cupples explained that the role of the FMO is to carry out medical examinations on behalf of the police. Banbridge Police Station was a place he frequently attended in the early hours of a Sunday or a Monday morning. He was working on an on-call period of 24 hours from 07.00 hours on Sunday 29 April 2018. He was called in to Banbridge Police Station as a detained person was being brought in.

[109] At approximately 02.20 hours on 30 April 2018, Dr Cupples was present in the custody office when the deceased arrived at custody hatch.

[110] Dr Cupples told the inquest that he observed that the deceased was initially calm, but he was in an uninhibited state and although talking freely there was some slurring of his speech. As he was being booked in, he observed him state to police that his partner had sustained injuries when she had walked into a dumbbell earlier that night. Dr Cupples thought this was an unusual thing to say.

[111] Dr Cupples then observed that the deceased suddenly became aggressive and violent and attempted to strike police. Dr Cupples saw the police and custody staff restrain the deceased on the floor at the custody reception area.

[112] Dr Cupples estimated that the restraint lasted for a number of minutes. He stated that the restraint was beyond the hatch and out of his sight. He heard the deceased indicate to police that he had a pre-existing orthopaedic problem at his left wrist. It was at that stage, Dr Cupples formed the opinion that he should move forward out of the office to the corridor to observe, in case there was some serious damage to his wrist which would need medical treatment.

[113] When outside the custody office, Dr Cupples observed the deceased being restrained face down on the ground. He was around 10 to 15 feet away. He stated that the deceased's "medical state was stable".

[114] Dr Cupples did not examine the deceased at this time, having formed the opinion that it would have been impossible to examine him safely. When the deceased was taken to his cell, Dr Cupples believed he had a conversation with Sergeant Stevenson and his opinion was that he was fit to be detained, as he was vocalising therefore able to breathe, a normal colour, and there was no indication of circulatory difficulties; he was not fit for interview; and he required a further medical review. He then completed a PACE 15 Form and recorded that the deceased should have a full medical examination later at 09.00 hours.

[115] Dr Cupples told the inquest that during the time he observed the deceased he formed the opinion that he could be under the influence of alcohol or drugs. He stated that he had agreed with Sergeant Stevenson that he should be under constant observations.

Dr Richard Harrison

[116] Dr Richard Harrison gave evidence to the inquest. Dr Harrison was a registered medical practitioner in general medical practice for 41 years and an FMO for 34 years.

[117] Shortly after 07.00 hours on 30 April 2018, Dr Harrison was telephoned by Sergeant Grattan and asked to attend the custody suite and examine the deceased. He recalled that she had concerns about the deceased who had come off the bed onto the floor and had been incontinent of urine. There was no mention of him having suffered a seizure or a fit. Dr Harrison claimed that if he was told he had a fit, he would have instructed Sergeant Grattan to request an ambulance. He did not recall asking Sergeant Grattan any follow up questions during the conversation.

[118] At 08.00 hours, he arrived at Banbridge custody suite. He was briefed by Sergeant Grattan in the custody office. She informed him "he'd been lying on the floor, that he wet himself, that she'd gone in to see him afterwards, to extract information off him for me to help me in my job, that he'd told her that he'd epilepsy and he wasn't on anything for the epilepsy." He was made aware that he had been aggressive on arrival and he had to be restrained on the floor.

[119] Dr Harrison told the inquest that he was not informed that the deceased had a fit in his cell. He told the inquest that "it's I think blindly obvious on the CCTV that

he's had a fit. Or a seizure I would call it". He agreed that it was a medical emergency for which an ambulance should have been called. He explained that if he was told this on the phone before he attended, he would not have attended and would have advised that the deceased to be taken to hospital by ambulance and described it as "a no brainer". He stated that that was something he would have expected to be told. Dr Harrison agreed that Sergeant Stevenson would have been much better placed to provide him with a briefing than Sergeant Grattan.

[120] Before going to the deceased, Dr Harrison did not look at the PACE 15 Form completed by Dr Cupples or the custody record. He stated that he looked at both after his examination.

[121] The CCTV footage of the cell was played throughout the inquest. At approximately 08.06 hours, Dr Harrison entered the cell to assess the deceased. A police officer and two CDOs were present. The deceased was lying on the bed facing the wall with wet trousers. Dr Harrison went over to the deceased and introduced himself; he then asked him how he was and the deceased made a grunting response. He asked him again "what's wrong" and the deceased mumbled about having a headache or something wrong with his head and Dr Harrison repeated it back to him. Dr Harrison then looked under the blanket and asked if he wanted changed and then moved away from the deceased. A CDO offered to change him, and Dr Harrison agreed and then left the cell. He did not take any medical equipment with him. Dr Harrison was in the cell for 45 seconds.

[122] In relation to asking the deceased for consent for the examination, Dr Harrison told the inquest that he did not obtain consent as the deceased was "heavily intoxicated at that time" and "I assessed it wasn't appropriate to ask him for consent".

[123] In relation to history taking, Dr Harrison commented that the deceased was unable to give him that information due to his intoxication and "I'd already got the history that had been gleaned by the custody sergeant earlier". Dr Harrison told the inquest that there was also "a distinctive sweet smell of Buckfast". When asked why he didn't ask the deceased about other medical conditions, Dr Harrison replied "well, I don't think it would have been appropriate at that time due to his intoxication". When it was put to him that he did not try to ask, he agreed that he did not.

[124] Thereafter, Dr Harrison completed a PACE 15 Form at 08.20 hours, stating that the deceased was complaining of a headache, query history of epilepsy and denied taking any illicit drugs. Other than that, no history appeared to have been taken. Dr Harrison told the inquest that on examination, he was breathing well, easily roused and complained of a headache. Dr Harrison was aware from Sergeant Grattan that he was also alleged to have a past history of epilepsy but was on no medication.

[125] Dr Harrison told the inquest that the deceased appeared to be under the influence of alcohol, smelling strongly of intoxicating liquor and also drugs. He deemed him unfit for interview at that time and he arranged to review him later. The deceased remained on constant observation and required another review later that morning. During evidence Dr Harrison stated that at this time "it was in my head that he could have had a fit" through a process in his head, but his working conclusion was that the deceased was intoxicated either through alcohol, drugs or both.

[126] When asked if he performed the examinations one would expect to have taken place – assessment of conscious level, pulse, blood pressure, oxygen saturation and temperature; examination of the eyes and brief assessment of mental state, Dr Harrison replied that he had performed three of the examinations. He explained that the deceased was conscious, he took his pulse and Sergeant Grattan used an oximeter and checked his oxygen although not recorded anywhere by her. He accepted that he did not take his temperature or blood pressure. He stated that he did look into the deceased's eyes and they were equal and normal. His mental state was impossible to assess at that time.

[127] At around 08.45 hours, Dr Harrison was telephoned again by Sergeant Grattan and informed that the deceased had complained of headache and of reaction to bright lights. He could not recall the detail "but I remember that my response to her was that I wasn't surprised he'd a headache because of all the alcohol he'd taken".

[128] Dr Harrison reassessed the deceased at 10.50 hours. Dr Harrison's notes recorded that the deceased was complaining of a headache. The CCTV footage showed that Dr Harrison asked the deceased, who was lying on his back on the bed, how he was doing and how was his head. He leaned over and looked at him, and then Dr Harrison left the cell. Dr Harrison was in the cell for 21 seconds.

[129] Dr Harrison described how the deceased's condition had much improved, being awake and alert. He stated that the deceased denied being epileptic, as he had told Sergeant Grattan this information. According to CCTV footage of the custody hatch it would appear that Sergeant Grattan received this information between 13.20 and 13.30 hours. Dr Harrison confirmed that he did not ask the deceased about epilepsy during either assessment. Dr Harrison detailed that the deceased continued to smell of intoxicating liquor but was deemed to be fit for interview at about 13.00 hours. Dr Harrison recorded 'no' to any medications and accepted that he had not asked the deceased this question.

Constable Zoe Kenny

[130] Constable Zoe Kenny gave evidence to the inquest, which was admitted by way of Rule 17. At approximately 14.14 hours on 30 April 2018, she was on duty at Banbridge Police Station and commenced a digitally recorded interview of the deceased. She put questions to him about his suspected involvement in Assault

Occasioning Actual Bodily Harm and Threats to Kill his partner Ms Lana Shead and an Assault on Police following his arrest.

[131] During the interview the deceased denied all the offences stating that Ms Shead had jumped up from the sofa and hit her head accidently on the dumb bell weight that he was holding. He denied making any threat to kill and denied assaulting Constable Montgomery stating that police had punched him first. The interview terminated at 14.45 hours. She then cautioned the deceased and conferred the charges of Assault Occasioning Actual Bodily Harm, Threats to Kill and Assault on Police. The deceased made no reply and was charged to appear at Newry Magistrates Court on 10 May 2018.

Patrick Gillen

[132] Mr Patrick Gillen, the deceased's solicitor, gave evidence to the inquest, which was admitted by way of Rule 17. On 30 April 2018, he attended Banbridge Police Station to represent the deceased. He had a legal consultation with the deceased from 13.25 hours until 14.15 hours.

[133] During this consultation the deceased indicated to Mr Gillen that the "police had been rough with him". He stated that during his arrest he was wrestled to the ground by police and was punched and kicked. He went on to state that he was bundled into a police jeep and also that the police stopped the jeep on the main road and beat him again. He went on to state while he was in the police vehicle, a police officer hit him on the eye with his fist. He also acknowledged that he hit the police officer who did this.

[134] During the consultation Mr Gillen noted that that the deceased had a blood shot left eye. He also showed him what he said was swelling to his right knee, caused by the events surrounding his arrest.

[135] The deceased was then interviewed from 14.15 hours to 14.45 hours. Following interview, the deceased was charged with three offences. He was then released on police bail. The deceased was released from police custody at around 15.20 hours.

<u>Part 3: 1 May 2018 – events at 75b Drone Hill, Corbet, Banbridge and Craigavon Area Hospital</u>

Zoe Wilson-Brown

[136] Ms Zoe Wilson-Brown, sister of the deceased, gave evidence to the inquest, which was admitted by way of Rule 17. At around 14.30 hours on 1 May 2018, her mother called to her house and explained that she could not get in contact with the deceased. Ms Wilson-Brown knew that he had been fishing with Ms Shead on 29 April 2018.

[137] Ms Wilson-Brown subsequently contacted Ms Shead, and she confirmed that they had been fishing, went to the deceased's home, smoked cannabis and an

incident then occurred during which Ms Shead suffered a split on her head and the deceased telephoned for an ambulance, the paramedics telephoned the police, and the deceased was taken into custody. Ms Wilson-Brown later learned that around 15.00 hours on Monday 30 April 2018, the deceased was released and took a taxi home.

[138] As neither she nor her mother could contact the deceased on 30 April 2018 or 1 May 2018, she felt anxious as it was out of character.

[139] Given her concerns, at around 16.00 hours on 1 May 2018, Ms Wilson-Brown sent a Facebook message to Rachel Radcliffe, who lived next door to the deceased. She asked if Ms Radcliffe could call over and check on the deceased. She replied stating that there was no one home but that her husband Simon would check later.

[140] At around 20.30 hours, Ms Wilson-Brown received a phone call from Simon Radcliffe saying that he had been in with the deceased and that he did not seem right and had "been given a hiding". Ms Wilson-Brown drove immediately to the deceased's home arriving at around 20.35 hours. The deceased was standing by his breakfast bench, and she asked him if he was alright and he replied, "no, I can't read or write". He could not articulate what had happened to him. Ms Wilson-Brown described how his speech was not making sense and varied between confusion and partial responses.

[141] Ms Wilson-Brown suggested that they go for a drive and he walked to the car unaided. During the journey she spoke to him in an effort to find out what had happened to him, but he couldn't explain himself and held his head in frustration. Ms Wilson-Brown noticed that he had a black eye and he told her, "the police did it. The police beat me up. The police did it they wouldn't let me go to the toilet and I wet myself."

[142] The deceased appeared to drift in and out of awareness. He grunted in frustration, and his speech was very poor. Ms Wilson-Brown had witnessed him under the influence of alcohol previously but did not consider him to be drunk at that time.

[143] At around 21.00 hours, they returned to the deceased's home. The deceased went into his home. Mr Radcliffe approached Ms Wilson-Brown outside the house and asked whether the deceased should go to hospital, and she agreed given his speech, confusion, and injuries. On entering the house, they found the deceased unconscious on the floor, with his head against the base of the sofa. He was unresponsive for approximately 15 minutes. Ms Wilson-Brown called for an ambulance. He did not recognise her. The deceased was agitated, repeatedly grabbing and shaking his right arm and leg and appearing to be in pain.

[144] As she had first aid training, Ms Wilson-Brown raised the deceased's feet onto the sofa to get some blood back into his head. He came round and started moving but he still did not know who she was. He was cupping the back of his right knee

with both hands, shaking it and making a noise as if he was in pain and it was annoying him.

[145] There was no recognition from him. His eyes were wide open, but he was blank. The deceased then became agitated, started shaking and was attempting to get up. He wanted to get up off the floor. They managed to seat him on the sofa. All of this lasted about 45 minutes. Once seated, he started vomiting.

[146] At around 22.00 hours, she observed the right side of his face drooping, and he was foaming at the mouth. Mrs Radcliffe suggested he was having a stroke, and the ambulance service was updated.

[147] Ms Wilson-Brown first telephoned for an ambulance at 21.26 hours, and they arrived on the scene at 22.40 hours. The deceased was taken to Craigavon Area Hospital.

[148] At 06.00 hours on 2 May 2018, Ms Wilson-Brown received a text message from her mother informing her that the deceased had suffered a massive stroke. Later that day, the deceased was transferred to the Royal Victoria Hospital. Whilst in the Royal Victoria Hospital the deceased's health seemed to initially improve. Whilst he could not talk properly, he started to recognise people and interact. His speech was limited. He could say his family's names, but he could not form full sentences. On one occasion, Ms Wilson-Brown showed the deceased a picture of his son and he started to cry. They were hopeful that he would make a recovery.

[149] On 4 May 2018, the deceased returned to Craigavon Area Hospital, where he sadly passed away on 7 May 2018.

[150] Ms Wilson-Brown explained that the family wished to establish what had happened to the deceased and the circumstances of his death.

Simon Radcliffe

[151] Mr Simon Radcliffe, the deceased's landlord, gave evidence to the inquest, which was admitted by way of Rule 17. The deceased moved into the annex beside his home in June or July 2017. He described the deceased as "a good lad" and would have done anything for him. He was a bit of a handy man and assisted Mr Radcliffe building and plastering. The deceased loved fishing, and they would both go to the River Bann. He trained about half an hour every day, did weightlifting or went for walks into Banbridge. He had a weight bench and dumb bells. Any time they had a barbecue he would have come round and had a couple of beers. Mr Radcliffe helped the deceased get a job which he was due to start the Monday after he went into hospital.

[152] On 29 April 2018, Mr Radcliffe saw the deceased washing the yard and playing with his son and the dogs before leaving and going into town with Ms Shead.

[153] On 1 May 2018, following a message from the deceased's sister, Mr Radcliffe checked on the deceased at approximately 20.20 hours. He became concerned due to the untidy yard and closed blinds. The deceased let him in and initially spoke coherently, but then became confused, repeatedly referring to being arrested and assaulted by police, complaining of head pain, and pointing to his eye.

[154] Mr Radcliffe observed that the deceased's left eye was blackened and bloodshot. The deceased said he was tired, could not think clearly, and could not read. His speech deteriorated, and he became distressed and tearful.

[155] Mr Radcliffe encouraged the deceased to attend hospital, but he refused. He then got his wife to contact his sister Zoe Wilson-Brown who arrived at around 20.45 hours. After the deceased had returned from a drive with his sister, Mr Radcliffe entered the house with Ms Wilson-Brown and discovered the deceased lying on the floor with his head wedged on a cushion, against a sofa, appearing to have weakness on one side. They called for an ambulance. His condition worsened, his face appeared to droop, he vomited, became grey in colour and was unable to communicate. He remained on the sofa until the ambulance arrived.

Rachel Radcliffe

[156] Mrs Rachel Radcliffe, neighbour of the deceased, also gave evidence to the inquest, which was admitted by way of Rule 17. She had known him from childhood and described him as a "big softie" who helped her husband Simon on the farm with various tasks.

[157] She considered that in recent months he had been trying to improve his life. He tended to keep late hours and had limited visitors, aside from deliveries of takeaways or bottles of wine. They socialised occasionally. He was physically active and regularly exercised. She was aware he had previously used steroids but believed that more recently he used marijuana and consumed alcohol heavily.

[158] At around 15.30–15.45 hours on 1 May 2018, the deceased's sister Zoe asked her to check on the deceased. At around 20.00 hours her husband Simon checked on him, and he returned reporting that the deceased had a blackened, bloodshot eye and was speaking incoherently about being arrested and assaulted. She contacted the deceased's sister Zoe, who attended.

[159] At around 21.20 hours, Mrs Radcliffe received a call from her husband asking her to come over to the deceased's house as there was something wrong with the deceased. She found the deceased lying on the floor, unresponsive, able only to grunt. His eyes appeared to roll back, and he began to experience tremors affecting his whole body.

[160] His mouth had started to droop, and she contacted the ambulance service again. The deceased briefly improved before vomiting and then experiencing further tremors. Mrs Radcliffe then went outside to direct the ambulance on arrival.

Jacqueline Wilson

[161] Ms Jacqueline Wilson, mother of the deceased, gave evidence to the inquest, which was admitted by way of Rule 17. She described how her son was born Banbridge District Hospital on 29 July 1984 and was one of six children. They all remained very close and would have regularly seen each other at family get togethers. The deceased was diagnosed with learning disabilities when he was about eight or nine years old. He left Banbridge High School when he was sixteen years old and he undertook a course in car mechanics with a view to progressing in it as a career. However, due to his learning disabilities he left the course and this disheartened him.

[162] The deceased began to work with Ms Wilson's partner, doing all sorts of jobs including landscaping, gardening and building. At the time of his death, the deceased had secured employment in Dublin through a friend.

[163] The deceased had a son with a former partner, whom he loved spending the weekends with. Ms Wilson described the deceased's life as simple and centred on family, hobbies, and close friendships. He always looked after himself and began bodybuilding from the age of seventeen. Ms Wilson stated that she did not know the deceased had been taking steroids and only found out when he was in the Royal Victoria Hospital.

[164] Ms Wilson told the inquest that the deceased was a heavy drinker. He drank Buckfast. When drinking he became loud and funny, but never aggressive. She was aware that the deceased would have taken 'blow' or herbal cannabis at parties.

[165] On 1 May 2018, Ms Wilson asked her daughter Zoe if she could get in contact with the deceased as she was unable to. At around 21.00 hours on 1 May 2018 Zoe telephoned Ms Wilson and advised that she was concerned about the deceased's behaviour. She tried to speak with him over the telephone, but his speech was incoherent. The phone call ended and Zoe telephoned her again from inside the deceased's home advising that he had been sick and she had called for an ambulance.

[166] At around 02.00 hours on 2 May 2018 Ms Wilson received a phone call from a consultant in Craigavon Area Hospital asking her to attend. She arrived at around 03.50 hours and was informed the deceased had taken a massive stroke. He sadly passed away on 7 May 2018.

[167] Ms Wilson paid tribute to her son, describing him as a lovable fellow, who was very loyal and loved her to bits. He loved all his family equally and loved being around them at barbeques or at family get togethers. She stated that she misses his wee phrases like "chin up" or "don't let anything get you down" and added that anybody who ever made a friend with the deceased was his friend for life.

Dr John McKenna

[168] Dr John McKenna, locum Senior House Officer in the Emergency Department of Craigavon Area Hospital, gave evidence to the inquest by way of Rule 17. The deceased arrived by ambulance at 23:52 hours on 1 May 2018 and was triaged shortly thereafter with confusion and right-sided weakness, prompting activation of the stroke thrombolysis pathway. He explained that thrombolysis is a treatment for stroke and involves administration of intravenous medication to break down clots in the brain.

[169] The deceased was subsequently deemed unsuitable for this treatment, and his care was handed back to the emergency department team. Dr McKenna reviewed the deceased at 00.20 hours on 2 May 2018. The deceased could not provide him with any information and information available at that time was provided by Northern Ireland Ambulance Service staff. He was noted to have been last seen well two days previously. He was reportedly found by a neighbour, confused with right arm and leg weakness.

[170] Clinical observations were within normal limits, though his Glasgow Coma Scale was 11/15. Bruising around the left eye was noted. Due to reduced consciousness, a full neurological examination was not possible, but reduced power was observed on the right side.

[171] Dr McKenna noted abrasions to the right side of the back and left side of the chest. Cardiovascular, respiratory and abdominal examinations were all otherwise normal.

[172] At 01.37 hours, the deceased underwent a CT scan of his brain which showed a large left sided cerebral infarct, meaning a stroke affecting the left side of the brain with associated swelling There was no haemorrhage. He was referred to the stroke team for ongoing management.

Dr Michael McCormick

[173] Dr Michael McCormick, a Consultant Physician in Craigavon Area Hospital, gave evidence to the inquest, which was admitted by way of Rule 17. He reviewed the deceased on the stroke ward on 2 May 2018. He identified clinical features of a severe left hemispheric stroke, including right-sided paralysis, facial weakness, dysphasia, and visual field loss.

[174] Dr McCormick's clinical impression was a left middle cerebral artery infarction secondary to a carotid dissection. Imaging confirmed occlusion of the left internal carotid and middle cerebral arteries. Arrangements were made for transfer to the Royal Victoria Hospital for further assessment and possible intervention.

[175] Following transfer back to Craigavon Area Hospital, the deceased deteriorated. Imaging indicated further stroke and haemorrhage complications associated with raised intracranial pressure. The deceased's condition was deemed irreversible.

Dr R C N Clarke

[176] Dr RCN Clarke, Consultant in Anaesthetics/Intensive Care, gave evidence to the inquest, which was admitted by way of Rule 17. On 7 May 2018, Dr Clarke, along with a colleague carried out brain stem testing on the deceased. These tests confirmed death, which was formally pronounced at 11.15 hours.

Part 4: Expert evidence – police restraint

Ms Joanne Caffrey

[177] Ms Joanne Caffrey, former police custody sergeant in Cumbria Constabulary and expert in safer custody, prepared a report for the Police Ombudsman for Northern Ireland and gave evidence to the inquest. She explained that, although England and Wales, Scotland and Northern Ireland have separate governance structures, Northern Ireland has adopted the College of Policing guidance in the same way as England and Wales. She was asked to provide expert opinion on the restraint of the deceased during transport to custody, within the custody suite, and on the floor in the cell, and whether that restraint was acceptable and within normal practice.

[178] Ms Caffrey told the inquest that her overall view was that the deceased's custody "should have been safer than it was". She identified a number of factors which, in her opinion, would have improved safety.

[179] Ms Caffrey detailed that the first of these factors was the use of body worn cameras during transit to custody and the use of caged vehicles. The inquest viewed a large volume of footage taken from the Body Worn Cameras worn by police officers. Ms Caffrey accepted that PSNI policy does not mandate its use and none of the officers travelling with the deceased had their cameras activated during transit. Ms Caffrey noted that officers are trained to consider the risk assessment for the mode of transport from the moment of arrest, as this may affect the level of force or risk involved during transit. She observed that the advantage of caged vehicles is that they do not expose officers to additional risk when seated alongside a detained person. She agreed that one of the factors that will obviously be taken into account is the availability of such vehicles.

[180] Ms Caffrey indicated that reports of the deceased banging his head against the window could have caused a potential head injury and that this information should have been passed to the custody sergeant and then discussed with the FMO. She also considered that the use of force, including prising fingers, and use of pressure points and strikes, should have been reported to enable a medical examination. She added that "based upon the officers' description of violence from Mr Wilson, the officers' attempts to prevent Mr Wilson causing harm to himself or others are within a reasonable response" but noted that "the use of a different vehicle may have prevented the situation occurring".

[181] Ms Caffrey explained that the second factor was the use of a safety officer during custody restraints. She accepted that the deceased lunged at Constable Mackin and that this was "an unexpected and unacceptable level of violence towards an officer", making restraint a reasonable response. She described the role of the safety officer (or "head officer") as conducting basic safety checks, including breathing, responsiveness, and appearance, and communicating those observations to the team. Training encourages the safety officer to identify themselves and provide ongoing updates during the restraint.

[182] Ms Caffrey was of the view that no officer was specifically designated to that role. While the deceased was communicating when prone, she indicated that "you would expect the safety officer to be saying… his breathing is normal, his colour is normal" and confirming that checks were being carried out. She emphasised that the role becomes more important where a detained person is restrained in the prone position. She noted that the deceased was at this time "on the floor in excess of 6 minutes, mostly in full prone" and observed that officers should minimise pressure on the torso and move the detainee into a side position as soon as possible.

[183] Ms Caffrey outlined that the third factor was the role of the custody sergeant in supervising restraint. She explained that custody sergeants should not generally be physically involved in the use of force, as this preserves independence and allows them to maintain oversight, assess risk, and coordinate between officers and healthcare staff. She observed that being "*hands on*" may reduce the ability to maintain a calm overview and make effective decisions.

[184] The fourth factor identified by Ms Caffrey was that the cell relocation technique should have been carried out more quickly. She indicated that once the deceased was secured, he should have been moved into the cell promptly and restraints removed as soon as possible. She commented that "there were other options available", including removing restraints more quickly and maintaining close observation. She described the relocation technique as requiring it to be carried out "quickly but safely" to allow prompt removal of restraints and access to medical care.

[185] In relation to Sergeant Stevenson's direction to "take a breather", Ms Caffrey expressed the view that this would only have been of value if used to facilitate medical assessment or to provide reassurance to the deceased. She added that "just being left whilst the officers took a breather, I didn't see the necessity for that, and it is certainly not what officers are taught".

[186] A linked factor concerned the removal of restraints in the cell and medical considerations. Ms Caffrey explained that once the objective of moving the detained person to a cell is achieved, the next priority is to remove restraints and obtain medical assistance. She indicated that, while this is a dynamic decision for the custody sergeant, having regard to threatened risk, powers and policy, the starting principle is that a detained person should not remain restrained in a cell without strong justification.

[187] Ms Caffrey described the relocation technique in detail. She advised that the use of handcuffs and leg restraints appeared to her to be within reasonable parameters but took issue with the duration, stating that "the duration of the restraint appears disproportionate for the level of violence offered and the number of staff present". She also observed that she was not aware of any reasonable grounds why the deceased was not attended by an FMO with restraints in place.

[188] A fifth factor identified by Ms Caffrey was the need for annual refresher training for custody staff on preventing deaths in custody. Since 2006 the College of Policing has stipulated that all custody staff should receive annual refresher training to focus on risk factors, vulnerability, and warning signs around preventing deaths in custody. She clarified that this is distinct from the PSNI's Personal Safety Program (PSP) which is general use-of-force training.

[189] The sixth factor concerned the involvement of healthcare practitioners. Ms Caffrey noted that the deceased was classed as a Level 3 and Level 4 detainee, and that mandates a medical review and rousing checks. She expressed the view that a detained person should not be downgraded to a Level 2 from Level 3 or 4, without medical advice and review, in line with 'College of Police Authorised Professional Practice for Detention in Custody' guidance.

[190] When asked about medical review during restraint, Ms Caffrey considered that, in her view, "it was safe enough to conduct a level of clinical examination" both in the custody area and in the cell while the deceased remained restrained.

[191] In relation to the scheduled FMO review at 09.00 hours, Ms Caffrey explained that responsibility rests with the custody sergeant, who is accountable for the deceased's welfare. While the FMO provides advice, the custody sergeant determines timing and can require earlier assessment if necessary.

Part 5: Expert evidence - Forensic Medical Officers

Professor Farnan

[192] Professor Farnan provided a report on behalf of Dr Brian Cupples, which was admitted into evidence under Rule 17. He outlined that during the restraint, Dr Cupples became aware that the deceased was complaining of a problem with his wrist and left the office to observe. He satisfied himself that nothing untoward was occurring and certified the deceased as fit for detention (he was already on constant observations), with a review arranged for 09:00 hours.

[193] Dr Cupples indicated that it was not possible to safely examine the deceased due to his violent behaviour. Professor Farnan expressed the view that Dr Cupples behaved appropriately in those circumstances.

[194] Professor Farnan explained that observation is an integral part of "examination" and, in this scenario, was likely as much as could safely be done. An

experienced FMO can assess airway, breathing and, to a degree, circulation through observation.

[195] In relation to Ms Caffrey's comment that, while restrained in the prone position, "The Doctor could have provided advice to the officers, without being involved in the restraint", Professor Farnan noted that Dr Cupples did observe the restraint (unasked) to ensure nothing untoward was occurring, particularly regarding the wrist. He indicated that this would have allowed assessment of airway, breathing and general circulation. If nothing concerning was observed, it was unclear what further advice could have been given. He added that any further examination would have required consent, which would have been problematic given the deceased's apparent intoxication, and that it was unlikely a significant abnormality would have been detected immediately after such a physical event.

[196] He further advised that supervision of restraint is a matter for the custody officer. The FMO is not expected to supervise restraint or examine a violent detainee, and it is unlikely that a person in such a state could provide informed consent, which is required for examination.

[197] In conclusion, Professor Farnan considered that Dr Cupples 'examined' the deceased as far as was possible in the circumstances. He was aware that the deceased was under constant observation and safety-netted the situation by arranging a later review when the deceased had regained capacity.

Professor Ian Wall

[198] Professor Ian Wall, GP and specialist in forensic and legal medicine, provided a report for the Police Service of Northern Ireland and gave evidence to the inquest. He was asked to review the actions of Dr Harrison.

[199] Professor Wall explained that careful and well-documented history-taking and examination are necessary to provide safe and effective care for detained persons. He noted that the doctor should be provided with background information from a member of custody staff, explain their independent role, and obtain consent. As a minimum, a detained person should be asked about medications, drug use, and chronic illness, including alcohol dependence, epilepsy and other relevant conditions. He accepted that in some cases an accurate history may not be obtainable.

[200] Professor Wall advised that a clinical examination should be carried out to assess objective signs and correlate these with symptoms complained of by the detained person. This information should inform decisions about fitness for detention or interview.

[201] He outlined that a basic clinical examination should include conscious level, pulse, blood pressure, oxygen saturation, temperature, examination of the eyes and a brief mental state assessment, with further examination as required. Injuries should be recorded and intoxication excluded where possible.

[202] Professor Wall explained that fitness for detention or interview is a clinical decision and highlighted the risks of detaining intoxicated individuals, including misattributing serious medical conditions to alcohol. He emphasised the importance of seizure history and noted that a first seizure, or a further seizure in custody, would generally require hospital transfer.

[203] In relation to the restraint in the corridor of the custody suite, Professor Wall agreed with Dr Cupples that it would not have been possible to carry out a formal examination due to the deceased's behaviour.

[204] Regarding events at 07.04 hours, when the deceased was found on the floor making unusual movements and incontinent of urine, Professor Wall considered it probable that he had suffered a seizure. He noted that this prompted the request for medical review and that custody staff sought to establish whether there was a history of epilepsy.

[205] Professor Wall reviewed CCTV footage of Dr Harrison's attendance at approximately 08.06 hours. Dr Harrison entered the cell without equipment and remained for 45 seconds. His notes on the PACE 15 Form recorded headache, a history of epilepsy, and denial of illicit drug use, with no further history taken.

[206] Professor Wall considered that a more detailed history should have been taken, particularly regarding alcohol intake and seizure history. He noted that incontinence can indicate seizure activity, stating that "importantly people who have a seizure are often incontinent of urine… so you'd want to ascertain further information to try and ascertain if this truly was a seizure or not". He accepted that examination is dependent on compliance and capacity, and personal safety, but maintained that basic questions could still be asked. He concluded that the history-taking was below the expected standard for an FMO.

[207] Professor Wall further noted that, aside from confirming breathing and responsiveness, no physical examination was undertaken and the whole assessment lasted 45 seconds. Professor Wall was of the opinion that a much more detailed examination should have been undertaken which should have included checking pulse, blood pressure, blood glucose, examination of the head to look for any possible head injury and examination of the eyes and that this would typically take 5–10 minutes. He did accept that breathing, airways and rouseability can be assessed without equipment very quickly, as Dr Harrison claimed he did. Professor Wall was of the opinion that the physical examination of the deceased by Dr Harrison was below the standard expected of an FMO.

[208] Dr Harrison advised that the deceased was fit for detention, with ongoing constant observation and further review later that morning. Professor Wall considered this appropriate if there was a known history of epilepsy. However, if the deceased did not suffer from epilepsy and Dr Harrison was informed of this and if this was a first seizure, he regarded the management as seriously below the standard expected of an FMO, as hospital transfer would have been required.

[209] At 08.45 hours, Dr Harrison was informed by telephone that the deceased was experiencing headache and photophobia. Professor Wall described this as a significant symptom, potentially indicating serious neurological conditions. He stated that whether the situation is monitored or whether a hospital transfer is requested is a matter of clinical judgment. He accepted that it could also be explained by alcohol use, noting that heavy alcohol consumption increases the risk of withdrawal seizures. In relation to the evidence of Ms Shead about the quantity of alcohol and drugs the deceased consumed in the past, he stated, "that suggests that firstly the person is maintaining a very high alcohol intake, an excessively high alcohol intake and it is likely that the person is dependent on alcohol. And a person who is dependent on alcohol, if their alcohol consumption is then stopped suddenly, they run the risk of having withdrawal seizures."

[210] Dr Harrison reassessed the deceased at 11.10 hours. CCTV footage showed he remained in the cell for 21 seconds and whilst the deceased responded to a verbal question, no clinical examination was undertaken. Professor Wall was of the opinion that a more detailed history should have been taken regarding the headache and indicated that there was no record of a physical examination.

[211] Given the likely earlier seizure and ongoing symptoms, Professor Wall considered that a more detailed examination should have been carried out, to include pulse, blood pressure, and assessment for head injury and neurological signs.

[212] Professor Wall told the inquest that, in the event that the deceased did not suffer from epilepsy and this was presumably a first seizure combined with headache and photophobia, he was of the view the deceased was not fit for detention and should have been transferred to hospital for further assessment. He noted that apparent improvement during the morning "would be a degree of reassurance… but it still doesn't explain why the person's had a seizure, never had one before and why they're now complaining of a headache."

[213] Professor Wall concluded by stating that he was of the opinion that Dr Harrison's assessment of the deceased was at least below, and possibly seriously below, acceptable standards at 08.06 hours, and that his assessment and management of the deceased at 11.10 hours fell seriously below acceptable standards.

Part 6: Expert evidence – pathology

Dr James Lyness

[214] Dr James Lyness, State Pathologist for Northern Ireland, gave evidence to the inquest. He conducted an autopsy on the deceased on 9 May 2018 and thereafter produced a report. Dr Lyness told the inquest that the cause of death was:

(a) Infarct of the left cerebral hemisphere

Due to

(b) Thrombosis of the left internal carotid and left middle cerebral arteries.

[215] Dr Lyness explained that in relation to 1(a) the cerebral hemisphere is the left half of the larger section of the brain and that the word 'infarct' means when the blood supply to the left side of the brain has been disrupted and the tissue on the left side of the brain has started to die or become degenerate which is a stroke. He further explained that the references to 'thrombosis' at 1(b) can be described as a clot which stopped blood flowing into the brain which then caused the infarct of the left cerebral hemisphere. The left carotid artery is a major blood vessel on the left side of the neck that supplies blood to the brain. The left middle cerebral artery is a branch of this artery that supplies blood to areas of the brain responsible for sensation, movement and language.

[216] Dr Lyness told the inquest that the post mortem examination confirmed the presence of a stroke within the left side of the deceased's brain. This infarct of the left cerebral hemisphere had been caused by disruption of the normal flow of blood to the brain, by a blood clot or thrombus. A CT scan taken whilst the deceased was in hospital had shown that this thrombus had initially formed within two of the main blood vessels supplying the brain – the left internal carotid artery and left middle cerebral artery. As a result of this stroke, the brain had become diffusely swollen within the rigid confines of the skull and eventually this cerebral oedema (swelling) had further obstructed the blood supply of the brain, resulting in widespread irreversible brain damage. This included bleeding into the part of the brain responsible for vital functions such as the control of breathing and the heartbeat. This irreversible brain damage was incompatible with life.

[217] Dr Lyness explained upon questioning that initially when a blood clot has formed within the blood vessels supplying the brain, it causes an area of the brain to die, which is the stroke, and that the body reacting to this injury causes the brain to become diffusely swollen which then further disrupts the flow of blood into the brain. In the deceased's case the swelling was so severe that it eventually caused bleeding into the part of the brain responsible for the heartbeat and breathing.

[218] Dr Lyness explained that thrombosis of the carotid artery (on the neck) or cerebral arteries (around the brain) may occur spontaneously, including, albeit rarely, in individuals of the deceased's relatively young age. In some cases, this may be associated with underlying natural disease, such as a raised blood pressure or an irregular heartbeat. Whilst there was some microscopic evidence to suggest that he may have suffered from a mild degree of hypertension, Dr Lyness noted that a GP blood pressure reading taken about one year prior to his death was normal. There was also no history of the deceased having been diagnosed with an abnormal heart rhythm, such as atrial fibrillation, a major risk factor for stroke. Indeed, Dr Lyness explained that the autopsy did not reveal any additional pre-existing natural disease to have precipitated or increased his risk of a thrombosis. He explained that as a pathologist, he was looking for other reasons why the deceased would have had a

naturally occurring stroke caused by a blood clot within their blood vessels, and none was present.

[219] Dr Lyness went on to describe how thrombosis of the arteries supplying the brain may also be associated with trauma and in view of the circumstances leading to the deceased's death the possibility that head and/or neck trauma may have caused damage to the delicate lining or wall of either the left internal carotid artery or left middle cerebral artery was considered by him. He stated that such traumatic vascular damage could have occurred during one of the known physical altercations he was involved in, as a result of his restraint by police officers, or secondary to a previous unwitnessed event.

[220] Dr Lyness explained that dissection of the neck muscles did not show any evidence of bruising to confirm that he had sustained significant blunt trauma to this region of his body, and therefore there was no physical evidence of such trauma or injury to the neck, although he stated that this could not be completely excluded. He went on to say that subsequent detailed microscopic examination of the left and right carotid arteries, in their entirety, also failed to reveal any evidence of dissection or any definitive evidence of vascular injury to pathologically confirm a traumatic aetiology.

[221] Dr Lyness confirmed that on the surface of the deceased's body there were bruises, most of which were fading or healing, which had multiple potential causes, and he confirmed they were not linked to the cause of death.

[222] Dr Lyness then went on to explain to the inquest how he used a microscope to examine the blood clot in detail. Microscopic assessment of the inflammatory response within the thrombus or cerebral infarct could provide an estimate as to the age of the lesions and in turn assist in identifying any precipitating events. He stated that a thrombus of the size identified in the deceased's case would not have developed instantly and would have been expected to have evolved over a period of time, probably hours or days. Indeed, the thrombus within the extracranial section of the left carotid artery appeared to be the earliest to have formed and was probably at the very least a number of days old. However, Dr Lyness stated that the inflammatory response to a blood clot can be highly variable and microscopic aging is not particularly accurate and could not differentiate between potential traumatic incidents in close succession to one another.

[223] Dr Lyness stated that of greater relevance in this case was the CCTV from inside the deceased's police cell which appeared to show decreased movement of the deceased's right leg and right arm whilst he was struggling on the floor. If correct, Dr Lyness stated that this could suggest that the deceased had suffered some form of temporary/transient stroke-like symptoms whilst in police custody and would therefore provide more accurate timing of the onset of symptoms. However, he stated that an independent clinical stroke physician should be asked to confirm/exclude this diagnosis and Dr Lyness confirmed to the court that he would

defer to Dr Hardie and Dr Patel in relation to the cause and significance of the seizure in the cell.

[224] Dr Lyness outlined that an increased risk of arterial thrombosis is also associated with some pharmaceutical medications and drugs of abuse. He went on to explain the toxicological analysis and results from a number of blood and hair samples that were collected from the deceased. He outlined how a low concentration of the chemical compound of cannabis was detected in the deceased's blood but clarified that its presence did not confirm that he was under the influence of drugs at the time the sample was taken. He explained that for toxicology, the ideal sampling is a sample close to the event and that in this case, the deceased survived for several days and therefore the blood taken at autopsy was not useful and taken approximately 40 hours after he was admitted to hospital.

[225] Dr Lyness then outlined the toxicology tests performed on chest hair root sections and summarised that they represented approximately a 10-day period before his death including those drugs present at the time of death. A trace amount of a compound of cannabis was detected, which suggested active consumption of cannabis during the days prior to his death. Codeine was also detected.

[226] Analysis of longer lengths of chest hair, expected to cover approximately a 5-month period before his death, detected a relatively low concentration of the ecstasy drug MDMA, recognised as a potential risk factor for vascular disease and the development of a stroke. A trace amount of two active constituents of cannabis was detected, which confirmed the deceased's use of this drug during this extended time period, and which also may be associated with an increased risk of acute ischaemic stroke. In addition, low levels of ketamine, fentanyl and diazepam, were detected, which were suggestive of his occasional exposure to these drugs. There were also low concentrations of a number of pharmaceutical medications including codeine, paracetamol, antidepressants, an antiepileptic drug and an antihistamine, all suggestive of occasional exposure to each drug. Two steroids were detected, both of which occur naturally in the body, but can be taken illicitly to increase muscle mass. The concentrations detected did not support his having actually administered either steroid in the previous five-month period.

[227] Dr Lyness opined that, in summary, there seemed little doubt that the deceased's death was ultimately the result of the infarct of the left cerebral hemisphere secondary to a thrombus within the left internal carotid artery and left middle cerebral artery. He deferred to Dr Hardie and Dr Patel in relation to whether the deceased had first suffered stroke symptoms whilst in the police cell, and whether this suggested a temporal relationship between the onset of thrombus formation and the sequence of events during the previous hours. He added, "had I been confident after my examination and extensive laboratory tests, etc, that restraint or trauma played a role in this death, or any other of the risk factors I tried to identify, I would have had a 1C in the cause of death, which I don't."

Professor Jack Crane

[228] Professor Jack Crane, former State Pathologist for Northern Ireland, was instructed of behalf of the legal representatives of the next of kin. He produced a report and gave evidence to the inquest. He told the inquest that having considered the autopsy report together with the expert reports of the consultant neurologists Dr Hardie and Dr Patel, "There would appear to be general agreement that his stroke was caused by thrombosis of the left internal carotid and middle cerebral arteries, however what it not clear is how the thrombus initially developed."

[229] In relation to Dr Hardie's suggestion that an episode of atrial fibrillation caused thrombus to develop in the left atrium of the heart and that fragments of this had broken off and had then travelled in the circulation to the left carotid artery, Professor Crane commented that, at autopsy there was no residual thrombus in the left atrium or other atrial abnormality such as an atrial system defect. It was Professor Crane's opinion that there was no definitive pathological evidence from autopsy to support the mechanism of carotid artery thrombosis proposed by Dr Hardie.

[230] Professor Crane added that the passage of time may account for a lack of residual clot, "I suppose there is the possibility that all the clot had gone from the left atrium. I think that's probably unusual, but I suppose it is possible".

[231] Professor Crane told the inquest that the possibility of neck injury precipitating the carotid artery thrombosis needed to be considered. This was considered by Dr Lyness who found no evidence of a dissection and similarly no dissection was seen on the CT angiogram. Professor Crane opined that "I think it can be stated with reasonable certainty that the cause of the stroke was not initiated by a carotid artery dissection".

[232] Professor Crane concluded that, "in this case it is thus very difficult to determine the underlying cause of Mr Wilsons' stroke. Whilst it is recognised that carotid and/or cerebral artery thrombosis may occur spontaneously, usually due to underlying disease within the arteries, it is uncommon in relatively young individuals such as Mr Wilson and without any inherent arterial disease."

[233] Professor Crane noted that it had been suggested, by Dr Patel, that the deceased's lifestyle, specifically alcohol and drug abuse, would increase the risk of development of a stroke and whilst he fully agreed with this, he stated that "it would nevertheless still be unusual for him to have taken a stroke at this relatively young age".

Part 7: Expert evidence – Neurology

Dr Richard Hardie

[234] Dr Richard Hardie, Consultant Neurologist, Rehabilitation and Stroke Specialist, prepared a report for the Police Ombudsman for Northern Ireland and gave evidence at the inquest. He was asked to provide expert opinion on a number of matters, including: whether the deceased experienced any temporary or transient

stroke-like symptoms while in police custody; the relationship, if any, between restraint and the onset of thrombosis; the possibility that the deceased may have displayed transient stroke-like symptoms, recovered, and later suffered a major stroke; whether the deceased was at risk of stroke based on his medical history, lifestyle, and family history; any additional factors increasing that risk; whether the medical treatment provided in custody contributed to his deterioration and death; and whether the time taken to obtain emergency medical assistance (approximately 1 hour and 40 minutes) contributed to the outcome.

[235] Dr Hardie identified the deceased's pre-existing conditions. He was 33 years old, with a documented history of substance and alcohol misuse, and was a smoker. Mild underlying cerebrovascular disease was noted at post-mortem, though this was not considered sufficient to account for the fatal acute ischaemic stroke.

[236] Turning to the cause of the cerebral thrombosis, Dr Hardie observed that the post-mortem findings demonstrated occlusion of a large intracranial artery. In his view, the most likely sources of thromboembolism in such circumstances were either the heart or the major vessels in the neck supplying the brain - the left internal carotid artery.

[237] One possible mechanism considered was traumatic dissection of the internal carotid artery. Dr Hardie noted, however, that Dr Lyness had examined the carotid arteries at post-mortem and found no evidence of dissection along their course. He advised the court that this mechanism could therefore be effectively excluded.

[238] Dr Hardie's opinion was that the most probable cause of the thrombosis was paroxysmal (episodic) atrial fibrillation (AF) (irregular heartbeat), a condition in which heart rhythm intermittently becomes irregular before returning to normal. He considered that embolism from the heart, arising from a physiological rather than structural abnormality, was the most likely mechanism. He noted that atrial fibrillation is a common disturbance of cardiac rhythm associated with a high risk of arterial embolism affecting the brain and other organs. Although initial ECGs showed normal sinus rhythm, he pointed out that many patients with acute ischaemic stroke are later found to have previously undetected intermittent atrial fibrillation.

[239] Dr Hardie further identified a number of risk factors in the deceased for paroxysmal AF, including alcohol misuse and the use of stimulant drugs such as ecstasy. He described how such substances can trigger the release of neurotransmitters, including adrenaline, activating the sympathetic nervous system and producing a rapid and potentially irregular heart rate.

[240] Dr Hardie then outlined what he considered to be the likely sequence of events leading to the fatal stroke. The deceased had consumed alcohol, been exposed to cannabis, and had been involved in a heated altercation prior to arrest. He subsequently displayed violent behaviour while resisting arrest. Dr Hardie indicated

that these circumstances could have predisposed him to an episode of paroxysmal AF, resulting in thrombus formation within the left atrium.

[241] He described how, some hours later, at approximately 06:50 on 30 April 2018, while the deceased was asleep in his cell, a thromboembolic event may have occurred, potentially causing complete occlusion of the left internal carotid artery, causing marked hypoxic ischaemia of the left cerebral hemisphere and precipitating a focal seizure. He noted that the CCTV footage did not demonstrate features consistent with a generalised tonic-clonic seizure attributable to alcohol intoxication or migraine. He considered it likely that this was followed by a short-lived post seizure weakness affecting the right side, which resolved within 10–30 minutes. He added that the lack of movement in the right upper and lower limb "was suspicious of the possibility that something on the left side of the brain wasn't working properly and of course that is the side where the stroke subsequently occurred. So, I was trying to connect the two. Now, it may be that they were unrelated, but it seemed to me to be a remarkable coincidence."

[242] Dr Hardie indicated that, had the deceased been taken to hospital shortly after this episode, a standard CT head scan would have been done and on balance, that would likely have appeared normal at that stage as the focal weakness had been fully recovered from within an hour or two of the seizure. He stated that a cardiogram would have been performed, though he was uncertain whether a CT angiogram would have been undertaken at this time. He stated, "I'm not sure that an angiogram would have been done. I think a standard CT head scan would have been done and on the balance of probabilities that would have been normal at the time if he had been taken straight to hospital within a few hours of the seizure."

[243] Dr Hardie went on to describe how, more than 24 hours later, further embolic events affected the dominant left hemisphere, initially producing fluctuating language disturbance and subsequently complete loss of language with dense right-sided paralysis. He described, how, in his opinion, a process whereby partial restoration of blood flow may have occurred, leaving residual thrombus fragments that later embolised and ultimately caused complete occlusion of the left middle cerebral artery on 1 May 2018.

[244] In relation to whether the deceased experienced transient stroke-like symptoms in custody, Dr Hardie considered that such symptoms probably did occur, although they were not typical of a classical transient ischaemic attack. He regarded them as more likely to represent post seizure affect.

[245] Dr Hardie found no direct relationship between restraint and the onset of the thrombosis formation.

[246] Addressing the possibility that the deceased experienced transient symptoms in police custody, recovered, and later suffered a massive stroke, Dr Hardie described the case as highly unusual. He advanced paroxysmal AF resulting in cardiogenic cerebral embolism as the most plausible explanation, involving initial

occlusion, partial resolution, and subsequent embolic events more than 24 hours later. In relation to Dr Patel's alternative view, that the seizure was unrelated and was a generalised seizure as a result of alcohol and substance abuse withdrawal, he indicated "Dr Patel might well be right, but I'm just putting this forward as a potential explanation. I'm not that confident about it because she makes a very good point, transient ischemic attacks don't normally cause seizures, but something mysterious was happening that I can't explain in any other way unless it is connected".

[247] When asked, Dr Hardie told the inquest that it was more likely than not that the seizure in the cell and the stroke was linked, and later he was "less than 50 per cent confident that there is a link" between the seizure in the cell and the subsequent stroke. He accepted that this was a contradiction in his evidence and commented that it was a very unusual sequence of events.

[248] Dr Hardie further indicated that the deceased's history of chronic alcohol and substance misuse would have significantly increased the risk of paroxysmal AF.

[249] In relation to the time taken in obtaining emergency medical assistance (approximately 1 hours and 40 minutes from the call to emergency services to the arrival of paramedics), Dr Hardie expressed the view that earlier intervention would not have altered the outcome, as the extent of ischaemic damage evident on imaging would already have been irreversible.

Dr Bhavini Patel

[250] Dr Bhavini Patel, Consultant Neurologist, was instructed on behalf of the next of kin to provide a second opinion and to comment on the conclusions of Dr Hardie. She also gave oral evidence at the inquest.

[251] Dr Patel drew attention to a discrepancy between earlier radiological opinion and the post-mortem findings. While a hospital CT angiogram had raised the possibility of a left carotid dissection as the source of the clot, she noted that the autopsy examination did not identify any dissection in either carotid artery.

[252] Dr Patel reviewed the deceased's background risk factors, noting that he was a smoker and had a history of substance use, both of which are associated with an increased risk of stroke and cardiovascular disease. Although the post-mortem demonstrated only mild disease, she observed that the heart showed relatively normal atrial structure, with moderate enlargement of the left ventricle. In light of this, she considered that the hypothesis of paroxysmal atrial fibrillation, as advanced by Dr Hardie, was not strongly supported by structural findings.

[253] However, she accepted that, in the absence of a more convincing alternative, paroxysmal atrial fibrillation remained the most likely underlying mechanism. She emphasised that arrhythmias are commonly seen in individuals, like the deceased with chronic alcohol and drug use, particularly where dehydration is also present,

and that these factors in combination could significantly increase the risk of an episode of atrial fibrillation.

[254] On the balance of probabilities, Dr Patel did not consider trauma to be the cause of the stroke. She reasoned that, if trauma had been responsible, there would have been evidence of dissection in the left carotid artery on post-mortem examination, which was not present.

[255] Dr Patel disagreed with Dr Hardie's suggestion that a stroke or transient ischaemic attack could have caused the seizure observed in the cell. She emphasised that, in her clinical experience, she had not encountered a transient ischaemic attack giving rise to seizure activity. Having reviewed the literature, she was unable to identify support for such a mechanism. She explained that, while seizures may occur following an established stroke, this would not be expected in the context of a transient ischaemic event from which the patient then makes a full recovery.

[256] In her view, the more likely explanation for the episode in custody was that it represented a generalised seizure related to alcohol use or withdrawal. She noted that the deceased also experienced headache, nausea, and sensitivity to light, which she considered consistent with migraine-type symptoms. She indicated that these features could arise in the context of dehydration and alcohol consumption.

[257] Dr Patel considered the CCTV footage of the episode in the cell. While she agreed that it did not demonstrate a classical generalised tonic-clonic seizure, she explained that there are recognised variants in which movements may be asymmetrical. She accepted that there appeared to be weakness affecting the right side following the episode but advised that this could be explained by Todd's paresis, a temporary post seizure weakness resulting from exhaustion of the motor cortex following a generalised seizure. She indicated that such weakness may persist for a period of minutes to up to an hour before resolving.

[258] She did not consider the footage to provide clear evidence of a TIA and a seizure. While she accepted that Dr Hardie's interpretation was a possible explanation, she regarded it as less well supported and maintained that a generalised seizure remained the more likely account.

[259] In addressing the timing of the stroke, Dr Patel placed weight on the CT findings. She noted that imaging at 01:37 hours demonstrated an established infarct with associated swelling. She was of the opinion that this would indicate that the stroke had occurred at least several hours prior to the scan but was unlikely to have occurred as early as 24 hours beforehand. She further observed that the deceased had been walking, speaking, and able to return home after his release from custody, which was not consistent with an established stroke at that stage.

[260] Dr Patel therefore concluded, on the balance of probabilities, that the stroke occurred after the deceased had returned home on 30 April 2018.

[261] Dr Patel did, however, acknowledge a possible alternative mechanism discussed by Dr Hardie, namely that a clot may have been present but had not yet fully occluded a cerebral vessel, resulting in a transient reduction in blood flow sufficient to trigger a seizure in the cell. She described this as a hypoperfusion type of seizure, and not a TIA. She added that, it was possible, that later on, "that blood clot then threw off another clot which is how that would have happened. So, I can agree with Dr Hardie that yes, the first evidence could be that there was one clot which hadn't quite reached the brain but it was bad enough to cause a seizure, i.e., it wasn't really a TIA, it was a hypoperfusion, type of seizure and that's what we witnessed on the video where there was not enough oxygen. And then later on, unfortunately, when out and about is when that clot flew out and it landed in the brain."

[262] Dr Patel found no evidence to support a causal link between restraint or any alleged assault and the occurrence of the stroke.

[263] She also considered that the deceased may have been dehydrated following a prolonged period of alcohol consumption and limited intake of fluids while in custody and thereafter. She stated that this can increase risk of clotting with a background of smoking. Dr Patel concluded that therefore, atrial fibrillation, in combination with dehydration, with the baseline platelet dysfunction caused by smoking and alcohol, could have caused the deceased's stroke.

[264] In conclusion, Dr Patel emphasised that the stroke was unlikely to have resulted from a single cause. Rather, she considered that it arose from a combination of interacting factors, including alcohol use, dehydration, smoking, and possible cardiac arrhythmia. She observed that it was this combination which made it difficult to identify a single definitive cause and explained why both experts were unable to express their conclusions in absolute terms.

Conclusions on the evidence

[265] In reaching my conclusions, I have carefully considered all of the oral, video and documentary evidence adduced during the course of this inquest. The findings set out below are made on the civil standard of proof, namely the balance of probabilities.

Transport to custody and use of force

[266] I find that the deceased was intoxicated at the time of his arrest, having consumed alcohol and drugs, and that his behaviour became increasingly unpredictable during transport to custody.

[267] I find that, whilst initially cooperative, he became aggressive in the rear of the police vehicle and gripped Constable Montgomery's forearm with significant force, requiring intervention.

[268] I am satisfied that Constable Montgomery applied pressure points and strikes in an attempt to release his arm and to prevent harm.

[269] I find that, in general, the use of force in the police vehicle was a reasonable and proportionate response to the threat and risk posed by the deceased.

[270] However, I find that Constable Mackin's kick towards the deceased's hands was not a recognised or trained technique and should not have been used.

[271] I further find that the deceased struck his head against the vehicle window during transport. This raised the possibility of head injury and was relevant information which should have been communicated on arrival at the custody suite in Banbridge Police Station. Had this information been passed to the custody sergeant during the booking process, it is likely that the FMO would have been informed in due course.

[272] I find that none of the above matters caused or contributed to the death, nor did they have any bearing on the overall outcome.

Communication and risk assessment

[273] I find that Sergeant Stevenson, as custody sergeant, was not adequately informed of the events during transport, including the nature and extent of the force used by officers.

[274] I am satisfied that this information would have been relevant to the assessment of risk and welfare, particularly given the deceased's intoxicated state.

[275] I find that the failure to communicate this information represents a departure from best practice.

[276] However, I do not find that this failure had any material impact on the eventual outcome.

Restraint in custody

[277] I find that, soon after arrival at the custody suite, at approximately 02.20 hours, the deceased became aggressive and displayed an unacceptable level of violence, and that the initial use of force and restraint by police officers was justified in order to prevent harm.

[278] However, I find that Constable Morrison's use of a headlock was not a recognised or trained technique and should not have been used.

[279] I find that the deceased was restrained by multiple officers, placed in a prone position, handcuffed and fitted with leg restraints due to the level of resistance offered.

[280] I am satisfied that the initial restraint was necessary in the circumstances.

[281] I find, however, that the deceased remained restrained in the prone position in the corridor for longer than was necessary once he had been brought under control.

[282] I am satisfied that he should have been relocated to a cell more promptly.

[283] I find that restraints were removed incrementally over a period of time, with handcuffs remaining in place until approximately 04.26 hours.

[284] Whilst it is acceptable in principle (and often good practice) to reduce the level of restraint incrementally, I find that the deceased was restrained for longer than was appropriate in all the circumstances, after he had calmed down.

[285] I also find that the deceased remained in the prone position in the cell for longer than was appropriate.

[286] I accept that he was observed throughout, was communicating, and that no signs of respiratory distress were identified.

[287] I find that, although aspects of the restraint fell below best practice, particularly in relation to duration and positioning, they did not cause or contribute to the deceased's death.

Observations and events in the cell

[288] I find that the deceased was initially subject to Level 4 observations, which were reduced to Level 3, and then to Level 2 intermittent observations shortly before the relevant incident.

[289] I am satisfied that this reduction occurred at a time when the deceased appeared to be settled and asleep.

[290] I find that at approximately 06.50 hours the deceased exhibited abnormal movements whilst on the bed in the cell, predominantly under a blanket, and that these movements included involuntary activity consistent with seizure activity.

[291] I accept that this episode was not directly observed, either in person or on CCTV, by custody staff.

[292] On the balance of probabilities, I find that when the cell was checked by CDO McNiece, the deceased had either just fallen from the bed or was in the process of doing so.

[293] I find that the deceased was subsequently observed, both on CCTV and in person, by Sergeants Stevenson and Grattan and CDO McNiece on the floor displaying abnormal movements, and urinary incontinence.

The seizure in the cell

[294] I have considered the differing expert opinions in relation to the episode which occurred in the cell at approximately 06.50 hours. I prefer the evidence of Dr Patel that, on the balance of probabilities, the deceased suffered a generalised seizure at that time, rather than a focal seizure associated with evolving stroke.

[295] I accept the medical evidence that there is no recognised causal link between transient ischaemic attacks and seizures.

[296] I am satisfied that the seizure was most likely attributable to alcohol-related factors, including chronic alcohol use, possible withdrawal and dehydration.

[297] I find that this seizure was a separate and unrelated medical event and was not caused by, nor an early manifestation of, the stroke which occurred more than 24 hours later.

[298] I have also considered the alternative mechanism advanced by Dr Hardie, namely that paroxysmal atrial fibrillation may have led to an initial cerebral embolic event, with partial resolution and subsequent embolic phenomena culminating in stroke. While I accept that this represents a possible explanation, I find that it is less well supported by the evidence.

[299] To the extent that any transient reduction in cerebral perfusion may have occurred, I accept Dr Patel's evidence that such a process would be more consistent with hypoperfusion rather than a transient ischaemic attack.

[300] I am not satisfied that the episode in the cell was causally connected with the stroke which occurred more than 24 hours later. I find that these were separate events, arising in the context of shared underlying risk factors.

Response to the seizure

[301] I am satisfied that the deceased's presentation in the cell after 06.50 hours, including collapse off the bed, abnormal movements, and incontinence, taken together, indicated a potentially serious neurological event.

[302] By 07.04 hours, Sergeant Stevenson had sufficient information to prompt an urgent hospital assessment and, while he requested a medical review by an FMO, he should have erred on the side of caution.

[303] At a minimum, I find that a full and accurate account of the deceased's presentation and condition should have been provided directly by Sergeant Stevenson to Dr Harrison. This may have prompted a different clinical response.

[304] I find that Sergeant Grattan made reasonable efforts to obtain information from the deceased in order to assist in briefing the FMO.

[305] I find, on the evidence of Dr Hardie, that had the deceased been taken to hospital shortly after the seizure, a CT head scan would likely have been normal at that stage, given that he had recovered from the focal weakness and would not, on the balance of probabilities, have altered the eventual outcome.

[306] Having regard to the expert evidence, I am not satisfied that the failure to seek earlier hospital assessment caused or contributed to the death.

FMO Involvement

[307] I find that Dr Cupples acted appropriately in his role as FMO and, in the circumstances, there was little more he could reasonably have done.

[308] I find that Dr Harrison was informed that the deceased had come off the bed, had been incontinent of urine and was moving unusually, but he was not informed of the full extent of the presentation, including the right-sided weakness. I find that this failure resulted in a missed opportunity to obtain a fully informed clinical assessment.

[309] I find that Dr Harrison's first assessment at 08.06 hours, lasting approximately 45 seconds, was inadequate. A more detailed history should have been taken, particularly in relation to alcohol intake and seizure history, and a fuller clinical examination carried out.

[310] I find that Dr Harrison's second assessment at 11.10 hours, lasting approximately 21 seconds, was also inadequate and represented a further missed opportunity to reassess the deceased's condition.

[311] The quality of a medical examination is not necessarily measured by reference to its duration, but in the circumstances such as they were with the deceased in the cell, I find that Dr Harrison's examinations were perfunctory.

[312] I find that Dr Harrison's assessments fell below what would reasonably have been expected of an FMO.

Subsequent events

[313] I find that the deceased subsequently improved sufficiently to be interviewed and released from custody.

[314] I find that, as the day progressed on 1 May 2018, his condition deteriorated, as evidenced by incoherent communication and subsequent observations by family and friends.

[315] I find that the deceased's sister Ms Wilson-Brown, together with Mr and Mrs Radcliffe, acted appropriately and did what they could in response to the deceased's condition.

Hospital care and treatment

[316] I find that imaging at Craigavon Area Hospital confirmed a large left-sided cerebral infarct.

[317] I accept the medical evidence that, by the time of presentation to hospital, the infarction was already established and irreversible, and would have been apparent on imaging one to two hours earlier.

[318] I am satisfied that earlier intervention would not have altered the outcome.

[319] I find that the treatment provided at Craigavon Area Hospital and the Royal Victoria Hospital was both timely and appropriate.

Cause of death

[320] A post-mortem was performed, and I find that death was due to:

(a) Infarction of the left cerebral hemisphere

Due to

(b) Thrombosis of the left internal carotid and left middle cerebral arteries.

[321] I find, as agreed by the pathology and neurological experts, that any trauma before, during or after police custody did not cause or contribute to the death.

[322] I find that the restraint of the deceased did not cause or contribute to his death.

[323] I am not satisfied that any of the identified failings, whether individually or cumulatively, caused or contributed to the death.

[324] I accept the evidence of Dr Patel that the timing of the infarct was likely several hours prior to imaging but unlikely to have been as early as 24 hours.

[325] I am satisfied, on the balance of probabilities, that the stroke was caused by paroxysmal atrial fibrillation in the context of chronic alcohol and drug misuse, dehydration, and associated risk factors.

[326] I therefore find that the deceased died from natural causes.

Postscript

[327] The purpose of an inquest is to conduct a full, fair and public investigation into the circumstances of a death. This includes, where possible, addressing and allaying any rumour or suspicion in light of the available evidence.

[328] I acknowledge and recognise the profound loss suffered by the family of the deceased, and I commend them for the dignity and composure they have shown throughout these proceedings.

[329] The deceased was described by those who knew him as a loving and loyal person, devoted to his family. He was someone who valued time spent with those close to him, whether at family gatherings or in everyday moments. He was a much-loved father, son, brother and friend and had been seeking to improve his circumstances, having secured employment shortly before his death. His life, though not without its challenges, was centred on family, friendships and simple pleasures. His death at a young age represents a significant and enduring loss to all who knew him.

[330] It is my hope that these findings provide the family with answers as to how their loved one died and offer some measure of clarity in the circumstances of his death.