Neutral Citation No: [2020] NICoroner 4 ***Judgment: approved by the Court for handing down (subject to editorial corrections)****	***Ref:* [2020] NICoroner 4** ***Delivered: 19/11/2020***

IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF AN INQUEST INTO THE DEATH OF

Mark Neeson

Before: Coroner Mr Patrick McGurgan

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(1) The deceased, Mark James Neeson, born on 25 April 1988, of Larchwood, Banbridge, died on 15 December 2015.

(2) During the second year of studying for his 'A' Levels, the deceased had been socialising with friends in Belfast whenever he got separated from his group and was subsequently subjected to an assault. Following this incident he required counselling and medication. At the time of his death he was being prescribed Diazepam, Mirtazepine (an anti-depressant), Nitrazepam (for sleep), and Quetiapine (a major tranquillizer). He had also spent one week as an inpatient in Bluestone Psychiatric Unit at Craigavon Area Hospital.

(3) I received evidence from a number of witnesses, including the State Pathologist, Dr James Lyness, Dr Benjamin Swift (the medical expert instructed on behalf of the PSNI), Dr Nat Carey (the medical expert instructed on behalf of the next of kin), the mother of the deceased, a number of civilians and a number of police officers. I also considered a large number of statements admitted under Rule 17 and a number of exhibits. In addition, I had the benefit of watching relevant CCTV footage, which, at my direction, was enhanced and of also listening to police radio communications.

(4) It is not possible to recite all of the evidence in these findings although all of the evidence received by me has been carefully considered before arriving at these findings.

(5) In her evidence to the Inquest, Mrs Mary Martin, mother of the deceased, stated that following the serious assault of the deceased he was unable to complete his A-levels and that he started to socialise with what she believed to be the "wrong" crowd. He did however, gain a fitness qualification and was intending to set up his own business.

(6) In his evidence to the Inquest, Mr Patrick McGeown, stated that on 13 December 2015 he was at a friend's house in Banbridge from around 6pm. He stated that the deceased was also present along with a number of others. At around 11pm the deceased and Mr McGeown walked to a local bar where they both had more alcohol leaving between 3-4am. During the evening Mr McGeown stated that he witnessed the deceased consume cocaine, maybe snorting it 6 to 10 times.

(7) According to Mr McGeown he and the deceased left the bar around 3-4am, although the bar manager stated that they left around 1.30am and went to the deceased's house by taxi. Mr McGeown then believed that the deceased left the property in or around 7am in a taxi in order to go and obtain cigarettes. This was the last time he saw the deceased.

(8) In her statement admitted under Rule 17, Lauren Smylie stated that she went to the deceased's home in the early hours of 14 December arriving at 6.20am and the deceased was not present although other persons whom she did know were in attendance. Miss Smylie had presumed that the deceased was at his mother's house.

(9) In his evidence admitted under Rule 17, Mr David Moffatt stated that on the morning of 14 December 2015 he was working as a taxi driver. Mr Moffatt knew the deceased in his position as a taxi driver. He had been aware for 3-4 years that the deceased had been using drugs. On that morning he received a call to go to the deceased's property and collect the deceased. Mr Moffatt stated that he went to the

house between 7am and 7.15am. According to Mr Moffatt there was nothing about the deceased's behaviour that suggested he was high on drugs although he was aware that during the journey the deceased kept looking out of the rear car window as if he was being followed. Mr Moffatt dropped the deceased off at a local garage and this was his last encounter with the deceased.

(10) In his evidence to the Inquest, Mr Christopher Walsh, stated that he knew the deceased and his family and would have been friends with the deceased. On the morning of 14 December 2015 at approximately 7.30-7.35am he left his home as usual in order to travel to his place of work. As he was driving along the Dromore Road he witnessed a male running "full pelt" along the footpath. Mr Walsh pulled into the 24 hour garage and when inside he heard the deceased screaming:

"Walsh, help, help, Walsh".

(11) Mr Walsh described the deceased as bolting into the shop and grabbing him. He stated that the deceased was sweating, really pale, looking absolutely terrified and fearing for his life. The deceased was pacing and looking up and down the aisles of the shop making no sense. Mr Walsh took the deceased outside into the forecourt in order to talk to him. The deceased kept looking over his shoulder and was very paranoid and irrational. The deceased appeared to be convinced that someone had chased him the entire way, which Mr Walsh stated was not the case, as he had just driven up the road and there was no one about. Mr Walsh invited the deceased to get into the rear of his car and lie down and that he would lock the car in order to keep him safe. The deceased was very jumpy and kept questioning this suggestion. The deceased would not get into the car at this stage and started to phone someone. At this Mr Walsh returned to the shop in order to complete his purchases and on return to the forecourt the deceased appeared to Mr Walsh to be unwell, grey in colour, his eyes were dilated, and he was in a cold sweat. The deceased again refused to get into Mr Walsh's car and as a result fearing he would be late for his work, Mr Walsh proceeded to drive off slowly. At this the deceased shouted at Mr Walsh and then got into the car and shouted:

"Go, go, go, go, drive, and drive".

(12) Mr Walsh described how he then drove off with the deceased in the front passenger seat attempting to calm him down. Mr Walsh informed the deceased that he wanted to take him to Daisy Hill Hospital Accident & Emergency (A&E) Department. Throughout this time the deceased kept checking under the car seat using the torch on his mobile phone. The deceased was also convinced that they were being followed. The deceased then told Mr Walsh that he believed that individuals known to Mr Walsh had paid another individual to "do him in".

(13) Mr Walsh drove to Daisy Hill Hospital and as he was pulling into a parking space the deceased jumped out of the car and ran off. Mr Walsh then spoke to the individuals the deceased had mentioned and confirmed with them that the deceased had effectively imagined this. In fact, they had been at his property the night before into the early hours and had been wondering where the deceased had gone as he had simply got up and left for no reason.

(14) Mr Walsh tried to contact the deceased on his mobile phone and sent him a text message. The deceased did not respond and there was no further contact between the deceased and Mr Walsh.

(15) I find that Mr Walsh acted appropriately and in a timely fashion throughout.

(16) In her statement admitted under Rule 17, Ms Ann Allen stated that at the time she was a nurse employed in Daisy Hill Hospital. At approximately 7.50am she parked her car across the road from the hospital and was making her way into the main entrance when she was approached by a male, whom it is accepted was the deceased, stating:

"Can you please help me! Help me!"

(17) The deceased was not aggressive and Ms Allen pointed him towards A&E. Ms Allen believed from his demeanour that the deceased was on drugs. She could see that he was sweating. The deceased then left and Ms Allen saw him bang on the

door of a nearby house. Ms Allen proceeded to call the police as she believed he was going to get knocked down on the road. Ms Allen did not see any blood or injuries on the deceased.

(18) In his statement admitted under Rule 17, Mr William Canavan stated that at 7.30am he was in his kitchen whenever he heard a male voice in his back garden in addition to items being knocked over. The male was shouting and mumbling although Mr Canavan did not see him at any stage. A blood stain was subsequently found by police on the rear garden railings.

(19) Mr Kieran Donaghy gave evidence to the Inquest. He stated that on the morning of 14 December 2015 at approximately 8.15am he got up, put on some clothes and let his dog out. As he walked around the corner of his house he heard a noise and saw a young man standing up at the back of the houses. He believed it was to the rear of Mr Canavan's house. This individual was the deceased. He appeared "fairly hysterical" and proceeded to climb up onto the wall at the rear of the house and dived straight into a hedge. The deceased was shouting and screaming as if there was someone after him. Mr Donaghy believed the deceased appeared "deluded" and to be on drugs. The deceased then got back up onto the wall and jumped off it again into the hedge and into the neighbour's garden. He then climbed onto a railing at the rear of this property and appeared to be trying to get onto the adjacent porch roof. Mr Donaghy phoned the police at this stage and told them; "this man's going mad here". The deceased then left and Mr Donaghy watched him proceed along Dominic Street in the middle of the road with his hands out appearing to be trying to stop cars.

(20) Mrs Tanya Henry gave evidence to the Inquest. On the 14 December 2015 she was making her way to work with a colleague. She parked her car at Pool Lane and walked towards the junction of Dominic Street and Bridge Street. As she was doing this she heard a male shouting:

"Help me please".

(21) Mrs Henry then observed a male sitting on the roof of a car which was parked behind the adjacent houses. This male, whom I find was the deceased, asked Mrs Henry to phone the police and informed her that if he got down from the car roof he was going to be killed.

(22) Mrs Henry thought that the deceased was high on drugs and described him as being "totally out of it". Mrs Henry proceeded to phone the police. The deceased appeared to be foaming at the mouth and he then slid off the car and ran through a bed of shrubs onto Dominic Street. He proceeded to run in front of a bus and then jumped up onto the wall of the Jobs and Benefits Office. He then jumped off the wall and CCTV footage showed the deceased attempting to clamber onto the roof of another car and sliding off the bonnet and running towards the entrance of the building. He then climbed up onto a gate before he ran behind a lorry.

(23) Mrs Henry lost sight of the deceased at this stage before picking him up again within a few seconds lying in the road to the right and behind a lorry. Later that day Mrs Henry noted blood on the windscreen and bonnet of the car the deceased had attempted to climb up on. Mrs Henry did not observe any injuries on the deceased except for dried blood on his sleeve. She also did not at any time feel in any danger herself from the deceased.

(24) In his evidence to the Inquest, Mr Terry Bennett stated that on Monday 14 December 2015 at approximately 8.30am he was driving his lorry in Newry along Bridge Street. He could hear someone shout what he believed to be; "Help, Help".

(25) Mr Bennett observed three police cars two to his right and one in the middle of the road. The deceased was lying face down in the road being restrained by police officers. Mr Bennett stated that one officer was holding the deceased down with his hand or hands between his shoulder blades and another officer restraining his legs. The deceased was handcuffed at this time and was shouting; "get off me".

(26) Mr Bennett did not recall hearing anything that suggested the deceased could not breathe nor did he witness any marks or blood on the deceased. Mr Bennett was

confident that one of the officers had his knee on the ground as opposed to on top of the deceased during the restraint. The deceased appeared to be able to move his head freely at this time and he did not witness any officer act in a manner that would cause him concern.

(27) Mr Malachy Doran gave evidence to the Inquest. He stated that on the morning of 14 December 2015 he was working as a security officer in the Jobs and Benefits Centre, Bridge Street, Newry. He parked his car around 8.25am and on crossing the road in order to go to his workplace he noticed the deceased standing at the perimeter fence outside the Centre facing outwards towards traffic. The deceased then ran over to a box type lorry that was stopped at traffic lights in Bridge Street and tried to open the passenger side door but was unsuccessful. The deceased then went to the rear of the lorry shouting. The deceased's behaviour was erratic as if he was perhaps trying to get away from someone.

(28) Mr Doran did not observe any marks or injuries on the deceased. Mr Doran proceeded to enter his place of work and some 5 minutes later he observed police restrain the deceased. He thought perhaps the deceased had been knocked over by a car as the deceased was lying on the ground not moving about. He did not see police man-handle the deceased in any way during the time he observed matters.

(29) Mr David Kinney gave evidence to the Inquest. On the morning of 14 December 2015 he was driving directly behind a large lorry and was adjacent to the Jobs and Benefits Centre. The traffic lights were red so he and the lorry were stationary. The deceased came towards his vehicle and was unsteady on his feet. The deceased attempted to get in and under the trailer of the lorry in front but he appeared to keep falling over. Mr Kinney was of the opinion almost immediately upon observing the deceased but certainly at this stage that the deceased was high on drugs or alcohol. The deceased then rolled over to the right side out of the back of the trailer and into the middle of the road.

(30) Police arrived and two officers approached the deceased, turned him onto his front and handcuffed him. Mr Kinney was of the opinion that the officers dealt very

efficiently with the deceased and he had no cause for concern regarding how they dealt with the deceased during his period of observation. Mr Kinney was also of the view that the deceased did not resist the police.

(31) Constable Hutchings gave evidence to the Inquest. At the time she was a part time police officer with some 9 years' experience. She stated that she was on duty on the day in question with Constables Patten and Willis. Her crew were initially assigned to a call in relation to a break in and while on route she and the crew responded to a radio transmission stating that the suspect was in Bridge Street lying on the roof of a car. On arrival in Bridge Street she observed a male (the deceased) lying on the ground in the middle of the road being restrained by a Sergeant Young, Constables Braiden and Warnock.

(32) According to Constable Hutchings, Sergeant Young was holding the deceased down on the ground, face forward and handcuffed to the rear. Constable Hutchings described Sergeant Young as kneeling on the ground over the deceased with his hands on the deceased. She believed that the force being applied by Sergeant Young was proportionate.

(33) The deceased was fitted with limb restraints and according to this witness was; "shouting and screaming and his legs were flailing". The deceased was shouting; "Don't shoot me, don't kill me". Constable Hutchings stated in evidence that it appeared to her early on that the deceased needed to be checked out in hospital and as early as prior to being lifted from the ground following his restraint. She had never in her career had to deal with a situation such as this.

(34) She was surprised to learn that it took some 8 minutes from the time the deceased was placed in the police car to moving off as she felt that matters had moved faster than that at the time.

(35) Following being restrained the deceased was then lifted by police officers in order to be taken to a police car. According to Constable Hutchings the deceased

struggled during this manoeuvre and gave a "real struggle", "jerking" when police attempted to place him in the car.

(36) Whilst the deceased was in the rear of the police car Constable Hutchings stated that he tried to escape through the rear driver's door. On examining the CCTV footage of this aspect of the incident she accepted that she could see the deceased's head coming out of the rear of the car and striking the pavement.

(37) A decision was subsequently made to take the deceased to hospital but Constable Hutchings did not accompany this crew but followed in another car after having it restarted as it would not start immediately at the scene.

(38) In respect of her training, Constable Hutchings was of the opinion that as she was only part-time she had less practical experience than her colleagues as regards restraining individuals.

(39) In her evidence to the Inquest, Constable Genevieve Willis stated that on the day in question she attended Bridge Street with Constables Patton and Hutchings. On arrival she observed the deceased being restrained by Constables Warnock, Braiden and Sergeant Young. She described Sergeant Young as lying with his back over the back of the deceased who was lying prone on the ground. She offered to handcuff the deceased but Sergeant Young confirmed that he was already handcuffed and then limb restraints were placed on the deceased. Constable Willis described the deceased as; "kicking out, shouting and being extremely aggressive."

(40) The deceased was then lifted to the police vehicle by Constable Willis and a colleague. Constable Willis took the deceased's left arm and described him as "swinging on our arms, not weight-bearing and he was talking but not making much sense." Constable Willis continued to talk to the deceased and tried to keep him calm. He informed her that his name was Mark.

(41) Constable Willis was of the opinion that the deceased was not volunteering or assisting police to get into the car and that he stiffened himself up to almost a plank stature. The deceased was not making sense and stating; "Don't shoot me. Don't

shoot me". Constable Willis accepted in evidence that the deceased was not displaying the slightest trace of aggression at this time.

(42) Whilst he was in the rear of the police vehicle, the deceased quietened down and Constable Willis stood outside the car with the door open talking into him. At one stage he started to roll his head slowly from side to side and stated; "they are going to get me, they are going to get me, they are going to shoot me".

(43) Constable Willis stated that the deceased had kicked out at her whilst he was restrained in the rear of the police vehicle and that he pushed his weight up against her lower abdomen pushing past her to fall out of the car. On viewing the CCTV footage she accepted the deceased struck the right side of his head off the pavement.

(44) The deceased was placed back into the rear of the police vehicle and Constable Warnock sat with him. Constable Willis was the driver of the car.

(45) A discussion ensued as to whether or not the cell van should be tasked but Constable Willis realised that she had the keys of this vehicle on her person. A decision was then taken to take the deceased to Daisy Hill Hospital in order to have him medically assessed.

(46) Constable Willis did not check if the deceased had his seat belt on and the evidence suggests that he did not.

(47) On moving off from the scene Constable Willis activated the police vehicle's blue lights as she was facing oncoming traffic and was intending to drive across them. Once established in her correct lane she switched off the blue lights and then made her way to the hospital with no siren or blue lights activated. En route, the deceased became unresponsive and Constable Willis reactivated the blue lights on the police vehicle.

(48) On arrival at A&E Constable Willis ran into the department requesting assistance and on return instructed Constable Warnock to get the deceased out of the

car. One handcuff was disengaged and CPR was commenced once the deceased was out of the police vehicle.

(49) On reflection, Constable Willis accepted that the deceased should have been taken to hospital sooner and that more attention should have been paid to the time matters were taking on the ground.

(50) In respect of training, Constable Willis explained that the only training received in relation to excited delirium was an American video of a situation of excited delirium during a class.

(51) In his evidence to the Inquest, Constable Patton stated that on the morning of 14 December 2015 he was with Constables Hutchings and Willis as the observer. He was a probationary officer at the time. On arrival at the scene he noted a male (the deceased) lying prone on chevrons in the centre of the road. Sergeant Young and Constables Braiden and Warnock appeared to have restrained the deceased who according to Constable Patton was struggling, shouting "don't shoot me" and kicking out although he was not being abusive. He assisted Constable Braiden complete attachment of a leg restraint on the upper thigh and a further restraint to his ankle.

(52) The deceased was then lifted to his feet and moved to the police vehicle with Constable Patton walking behind the deceased. Constable Patton stated that he formed the view almost immediately upon arrival at the scene that the deceased had consumed drugs and needed to go to hospital or an ambulance tasked to the scene. Constable Patton did not believe that the deceased would have been accepted into custody by the Custody Sergeant in his condition.

(53) Constable Patton was unaware that there had been a discussion regarding requesting the cell van. He was of the opinion that the deceased was being difficult in not putting his feet to the ground when being moved to the police vehicle. According to Constable Patton there were no signs that the deceased was unconscious when being moved from the ground to the police vehicle.

(54) Constable Patton accepted in evidence that with hindsight this was a medical emergency and that the deceased should have been taken to hospital immediately or an ambulance tasked to the scene. He further accepted that with hindsight there was an avoidable delay in taking the deceased to hospital and that an ambulance should have been tasked to the scene at the same time police were.

(55) Constable Patton was referred to the PSNI "Manual of Policy, Procedure and Guidance on Conflict Management". He believed that he had read some of its contents but not all. He stated that he was not aware of "excited delirium" nor had that been mentioned by any officer at the scene. Constable Patton also confirmed that he has not had any training on 'excited delirium' since this incident.

(56) Under the heading: "Signs and Symptoms of Excited Delirium" some thirteen bullet points are listed. Constable Patton accepted that the deceased on the morning in question exhibited some twelve of the points listed.

(57) The manual also details "Controlling a Person in a State of Excited Delirium" where it states:

"Once they are handcuffed, do not hold them face down. They should be moved onto their side or into a sitting, kneeling or standing position as soon as it is safe to do so. They may continue to kick out. However, police officers must get them off their stomach in some way or other as soon as they can."

(58) And under the heading: "Once Control has been Achieved", it advises:

"If police believe or suspect that they are dealing with a case of Excited Delirium, the subject should be examined at hospital as a priority, regardless of any subsequent signs of apparent recovery…"

(59) In addition the Manual states under the heading: "Certain Restraint Positions of Persons Exhibiting Excited Delirium Increase the Risk of Death":

"Restraining a subject in a prone, stomach down position is particularly hazardous. This is increased if the subject's hands are handcuffed behind their back or to their feet."

(60) And:

"It should be remembered that obesity, alcohol and drugs increase the hazard still further by restricting diaphragm and lung function."

(61) Constable Patton accepted in his evidence that he did not believe that the deceased had been taken off his stomach as quickly as possible. He further stated that he did not think about Excited Delirium and nor had any other officer mentioned it at the scene. He also stated that the struggling, shouting, kicking out as described by him could have been the final throes of someone distressed being sat upon or kneeled upon and struggling for breath.

(62) He further accepted that there was an under appreciation by those present of the deceased's situation, that there was a lack of urgency by police in their dealings with the deceased and that Mr Neeson did not receive the level of supervision from police that he required.

(63) In his evidence to the Inquest, Constable Braiden stated that on the morning in question he was detailed as the driver accompanied by Constable Warnock. He was initially tasked to reports of a burglary and that the male (the deceased) was being detained at the scene and whilst en route received a further communication that the deceased had run off.

(64) He then received a further communication that the deceased was now in Bridge Street lying on the roof of a car, shouting and bleeding. The radio communications which were played in the Inquest also stated "approach with caution". Constable Braiden stated that on the journey to the scene he did not give any consideration to the possibility that the deceased may be a vulnerable person in light of these communications.

(65) In his statement he stated that on exiting the police vehicle at the scene the deceased was shouting, flailing his arms and legs. He subsequently accepted in his oral evidence and on watching the CCTV that there was no flailing of legs or arms by the deceased except for what appeared to be two kicks upwards whilst he was lying prone on the ground. He accepted that his statement was inaccurate in this regard and explained that his statement recorded his perception of events at the time.

(66) Notwithstanding the absence of flailing of either arms or legs, Constable Braiden stated that he would still make the decision to have the deceased put to the ground and restrained. He accepted that upon arrival there was no physical aggression on the part of the deceased although he was of the view that shouting by the deceased, comments such as "don't shoot me, don't kill me" and other incomprehensible shouts represented verbal aggression.

(67) He accepted that Constable Warnock resorted immediately, on exiting the police vehicle, to restraint without any signs of physical aggression on the part of the deceased. In addition, contrary to his statement, Constable Braiden accepted that on arrival at the scene the deceased was not lying face down on the ground but was attempting to get to his feet. He also accepted that he did not attempt to talk to the deceased when he first approached him.

(68) Constable Braiden stated that at no time did he give consideration that the deceased may have been involved in a road traffic collision despite the fact that he was first encountered lying in the middle of a main thoroughfare at morning rush hour.

(69) On reviewing further elements of the CCTV footage, Constable Braiden accepted that the deceased was held to the ground and that Sergeant Young was on the deceased's upper torso during the restraint and that pressure was being applied to the deceased's back as he was prone on the ground. He did not believe that Sergeant Young's actions in the restraint were appropriate after viewing the CCTV

although he did believe that Constable Warnock acted appropriately in the manner of the restraint.

(70) Constable Braiden described how the deceased was then restrained by way of handcuffs. Leg restraints were applied above the knees and ankles and a second set of restraints were used on his knees, as the first set were ineffective. The deceased was then lifted under each arm and taken to the police vehicle.

(71) Constable Braiden accepted that at no time during the restraint nor whilst he was being taken to the police vehicle, was the deceased physically aggressive but that he continued to be verbally aggressive. He had no concerns regarding the deceased's health at this time and Constable Braiden believed that the deceased maintained consciousness at all times between the restraint and being taken to the police vehicle as he (the deceased) continued to shout out during this time.

(72) Up until this time Constable Braiden was of the view that the deceased was going to a custody suite although he accepted that no Custody Sergeant would have accepted the deceased in his condition. That left the alternatives of street bail which would not have been an option or hospital for medical assessment.

(73) In his evidence he did agree with Constables Patton and Hutchings assessment that it was obvious from an early stage that the deceased would need to go to hospital.

(74) Constable Braiden told the Inquest that he had no specific training in "excited delirium" and that the training he had received was inadequate. He has still not received any specific training on the matter. He believed that if he had have been adequately trained he would have been better equipped to deal with the situation.

(75) Constable Braiden then explained that after placing the deceased in the rear of the police vehicle he returned to his own vehicle only to discover that it had a flat battery. Constable Patton and Hutchings went to assist to move the vehicle off the road by pushing same to a nearby garage.

(76) Constable Braiden did not believe that the police vehicle breaking down was a distraction to the other officers and if there had been an urgent need to transport the deceased to hospital, Constable Willis would have left the scene without the other officers.

(77) He did accept in his evidence that the 9 minutes before Constable Willis moved off with the deceased to hospital was too long.

(78) Once his police vehicle was restarted, Constable Braiden followed Constable Willis's vehicle to the hospital.

(79) Former Sergeant Young gave evidence to the inquest by way of live link, with his wife sitting proximate to him as a supporter, special measures that I had granted to him upon his application and after being medically assessed by two Psychiatrists instructed by me. The details of that decision on special measures are recorded in a written decision issued by me.

(80) Mr Young stated that at the time he was a Sergeant in the PSNI attached to Community Planning in D District. He had been in this role for a couple of months. This job entailed representing the District Commander and engaging with local Councillors and outside organisations in a community relations role. He was effectively the point of contact for all outside organisations. Prior to this job he was a neighbourhood policing Sergeant.

(81) Mr Young explained that whilst his new role was office based he was a proactive police officer and it was not unusual for him to assist colleagues if he was out on the ground. His working life at that time was quite stressful and he later reported sleep difficulties, that his mind was 'buzzing' and of feeling tired prior to the tragedy.

(82) He subsequently left the PSNI following this tragedy.

(83) On 14 December 2015 he was on duty and overheard a radio transmission in relation to a burglary suspect (the deceased) detained at an address in Newry. Mr Young went as a single officer patrol in order to assist his colleagues.

(84) Mr Young described his state of mind as being concerned for his colleagues, including whether or not they had their breakfast. On arrival at the address he spoke with the occupant who confirmed that the male suspect had left the area. Mr Young obtained a description of the suspect and relayed same to his colleagues via radio transmission. A further radio transmission from Communications stated that a possible suspect was sighted in Bridge Street.

(85) Mr Young proceeded to the location and on approach he saw Constables Warnock and Patton, who had already arrived, on the ground restraining the deceased. Mr Young accepted in evidence that it wasn't Constable Patton who was present but another officer whom he did not know. It was in fact Constable Braiden. He agreed that it was likely that he would have had a view of the deceased on the ground as depicted on the CCTV on his approach to the scene. On arrival Mr Young alighted from his vehicle and went to assist. According to Mr Young it was evident that his colleagues were struggling with the deceased. He also was aware from radio transmissions that there was CCTV trained on the incident. He stated that he assisted by restraining the deceased's legs whilst the other officers cuffed him.

(86) He believed that his intervention was necessary as he believed that the deceased had tried to commit a burglary and had tried to evade capture by police and was struggling with police.

(87) Mr Young explained that he went down to the deceased's lower leg region and he lifted and held onto his feet and crossed his legs to restrict any potential kicking out. He made an on the ground assessment that if the deceased was not cuffed he would try to get away. Mr Young described a lot of shouting occurring and that the deceased told him his name was "James". He denied that the deceased ever said "help". He could not recall if, as one civilian witness described, he placed his hand(s) between the deceased's shoulder blades. Nor could he remember if his knees were

placed onto the deceased. Mr Young then directed, that due to the deceased's demeanour and failure to comply with police, that Constables Warnock and Braiden place leg restraints on the deceased. Mr Young advised that he wanted to control the situation as quickly as possible as he was conscious that they were in the middle of the main road and for the safety of the officers and the deceased. He wanted it done professionally by everyone including himself and he would not have directed the use of leg restraints unless justified, necessary and appropriate.

(88) Mr Young could not remember the last time he restrained someone prior to this incident but said in evidence that he would have done so on a regular basis.

(89) The deceased was on his stomach at this stage and was communicating but was very incoherent. Mr Young stated that in order to allow the leg restraints to be placed on the deceased he moved upwards on him rolling up his legs, stopping on the lower part of his spine, the back area with his face facing down towards his legs and using his upper body lying upon him with his legs spread out and secured himself between the deceased's upper body region by getting between him and Constables Warnock and Braiden. He stated that his hips and bottom were on the ground beside the deceased and he was using his upper body weight. Mr Young described himself as being 90 kilos in weight at the time.

(90) The deceased was torso down on the ground with his head to the side still verbally communicating and still incoherent. Mr Young stated that he was talking to the deceased to reassure and calm him down and to try to identify him. At no time did Mr Young observe any injuries on the deceased nor did he form the impression at any time that the deceased was under the influence of alcohol or drugs although he did state to the Police Ombudsman that "actually my only conclusions was that he had drink taken was the reason because it was like slurred.."

(91) It was put to Mr Young that his colleagues, Constables Patten (a probationary officer), Braiden and Hutchings, all stated in evidence that it was obvious from an early stage that the deceased would need to go to hospital but he, an officer with some 26 years' service, stated that he did not form that impression at any point. In

fact, Mr Young went on to say that if any of his colleagues had thought that then they should have had the moral courage to have spoken out at the time.

(92) Mr Young was of the view that the force he applied to the deceased was the minimum necessary to control and make the situation safe. He accepted that as the Senior Officer on site he had to make certain decisions.

(93) Once secured the deceased was lifted by his upper arms and carried to the police vehicle by sort of hopping him. On review of the CCTV Mr Young accepted that the deceased was not moving his legs. According to Mr Young, he was still communicating and moving. At no time did Mr Young feel that the deceased lost consciousness although he did accept that the deceased when brought to his feet and being moved to the police vehicle, his head rolled or flopped forward. While he did not know if this represented someone who is "out of it" he stated that it could mean he (the deceased) was exhausted due to the struggle.

(94) At the police vehicle Mr Young stated that he held the deceased's right arm and Constable Warnock searched him. They then placed him in the rear of the police vehicle by the rear left passenger door. According to Mr Young at this stage the deceased was starting to become non-compliant and Constable Willis went around to the other side of the police vehicle and lifted his feet in as Mr Young lifted his legs. He was placed upright in the rear of the vehicle seated and according to Mr Young secured by the seatbelt applied by Constable Willis. Mr Young having no concerns then left the scene to go to another engagement. Mr Young stated that at no times did he have any concerns regarding the deceased. If he had, he stated he would have rendered first aid, "he would have dealt with it".

(95) At no time did any of his colleagues vocalise the need for the deceased to go to hospital and he believed that when he left the scene that his colleagues were taking the deceased to the Custody Suite in Banbridge.

(96) Mr Young was directed to the 2015 PSNI Manual, Policy, Procedure and Guidance on Conflict Management and in particular to Appendix E regarding

Positional Asphyxia and Excited Delirium. He was familiar with both concepts as it formed part of his training. He did not consider that at the time the deceased needed immediate medical attention for any injury internal or visible. As regards the risk factors listed in the manual for Positional Asphyxia, Mr Young was of the view that the deceased exhibited some of the factors but that would be normal for any arrest.

(97) Mr Young did accept that the deceased would fall into a risk category regarding Positional Asphyxia and Excited Delirium.

(98) He was also referred to the following excerpt within the Manual:

"Police Officers should be mindful of risks involved in using their body weight on the upper body of a subject during restraint. The prone position should be avoided if at all possible, or the period for which it is used minimised."

(99) Mr Young felt that the arrest was done in the most effective and quickest manner possible and after restraining the deceased he was immediately put into an upright position.

(100) Mr Young was also referred to the PSNI Code of Ethics 2008 at Article 4.1 entitled "Use of Force" and Article 5.1 and Article 5.2 entitled "Detained Persons". He believed that the deceased was treated with dignity and that he wanted to have the deceased removed from the road to be placed in the police vehicle in order to maintain his dignity. He was also taken through the 5-step communication model set out in the Personal Safety Programme (PSP) training guidance. He denied that this latter guidance suggested that a "softly, softly" approach be adopted to situations such as this and that it was more suited in an ideal world. He asserted that when he arrived, two officers were struggling with the deceased and whilst he was restraining him he was still attempting to calm him down. He was of the opinion that the minimum amount of force necessary was used and he denied landing with his knees onto the deceased.

(101) Mr Young was of the view that he had not made any mistakes in how he dealt with the situation. When he was asked if the struggling, shouting and kicking out as

described by him could have been the final throes of someone distressed being sat upon or kneeled upon and struggling for breath he replied that if he had thought that the deceased was in medical distress he would have done all that he could to alleviate that and that whilst anything is possible he did not honestly believe that (the struggling *etc*) to be the case.

(102) Mr Young believed that he acted professionally at all times, he did not snap. Following this tragedy Mr Young availed quite properly of Counselling sessions. He told his Counsellor on 8 November 2016 regarding this incident:

"Client views self as 100% responsible" and;

"Should have taken extra time to look and may have recognised signs of young man's presentation".

(103) In his evidence he stated that he did not believe that he should have taken extra time and that when he was at the scene his actions were appropriate and he made the correct assessments.

(104) In his evidence to the Inquest, Sergeant Rory Warnock stated that at the time he was a Constable attached to the local policing team at Ardmore, Newry. He had been a police officer for some 4 and a half years at that time.

(105) On 14 December 2015 he was detailed as observer with Constable Braiden. Observer meant that he would be in charge of any files/incidents that shift. At approximately 8.20am a radio transmission reported a male being detained by a person after attempting to break into houses. En route to the area there was a further radio transmission received from Sergeant Young, advising that he had arrived at the scene but that the male had left the area heading in the direction of the Simon Community and Sergeant Young also provided a description of the male.

(106) Constable Warnock headed in the direction of Bridge Street and en route a further radio transmission advised that a male was observed jumping on the bonnet of a car in Bridge Street. On arriving at Bridge Street, Constable Warnock stated that

he observed a male (the deceased) lying in the middle of the road face down. As he approached, the male continually shouted at him telling him to get away from him.

(107) Constable Warnock accepted that the information that he had received over the radio as regards the deceased set the tone as to his approach to the deceased on arrival. He explained that the National Decision Making Model sets out a 5 step process, the first of which is to consider the information/intelligence one has and that that is what dictated his actions here.

(108) At the scene he exited the police vehicle and jogged towards the deceased. The deceased at this stage attempted to get to his feet and Constable Warnock immediately put the deceased to the ground face down. Constable Warnock accepted that he used force before there was resistance from the deceased.

(109) Constable Warnock explained that his priority was to detain a suspected burglar who had already evaded capture. He did accept that with hindsight it would have been a possibility to have approached the deceased initially and hunker down beside him and speak with him or he and his colleague place their hands on his shoulders but at the time he felt that the deceased needed detained immediately given the information that he had been relayed via the radio.

(110) He stated that he informed the deceased that he was police and he described the deceased as aggressive, struggling and unpredictable. Constable Warnock could proffer no explanation as to why the word aggressive did not appear at this time in his notebook entry.

(111) According to Constable Warnock it was evident quite quickly that he (the deceased) had consumed drugs, alcohol or had a mental health issue. He considered drugs due to the deceased's behaviour and appearance. According to Constable Warnock the significance of drugs was that he would have to be more aware then of heightened aggression /paranoia on the part of the deceased. He and Constable Braiden attempted to place handcuffs on the deceased for his, their own and the

public's safety. Constable Warnock stated that the deceased immediately resisted police and continued to struggle and began kicking his legs out.

(112) On review of the CCTV footage Constable Warnock accepted that the deceased may not have been aggressive but was definitely resisting.

(113) Constable Warnock observed a cut to the deceased's left eyebrow and to both his hands. Sergeant Young then arrived on the scene. Constable Warnock accepted that Sergeant Young could be seen on CCTV applying positive downward pressure on the deceased's back and that Sergeant Young appeared to have his back on top of the deceased's back, a manoeuvre which he accepted was not required at that time.

(114) Constable Warnock used his police issue handcuffs and the deceased was also placed in leg restraints, both around the knees and around the ankles. Constable Warnock stated that he held the deceased's feet to allow for the restraints to be placed on him. He described the deceased as still lying face down, continually kicking out, with his face to the side and shouting. The CCTV footage whilst not capturing all of the initial incident did not appear to support the claim that the deceased was kicking out continually.

(115) Constable Warnock stated that he was not confident that he and Constable Braiden could control the deceased by themselves given the level of resistance by the deceased.

(116) The deceased was then lifted to his feet and searched by Constable Warnock at the car.

(117) Constable Warnock stated that he was aware of Positional Asphyxia and that was why the deceased was brought to his feet so quickly. Medical assistance for the deceased was not considered at this stage. According to Constable Warnock the deceased continued to resist as he was escorted to the police vehicle.

(118) Constable Warnock accepted that the deceased was carried to the police vehicle as opposed to being escorted and that it took 2-3 officers to hoist him up and further

that in fact the CCTV showed that the deceased was not resisting at this stage. Constable Warnock stated that he had no concerns at that stage about the deceased losing consciousness.

(119) Two radio transmission excerpts were played which were made by Constable Warnock at the time he was in the car with the deceased. On both occasions he describes the deceased as being "absolutely out of it." There was no mention of violence or resistance on the part of the deceased.

(120) Further at the time he did not consider Excited Delirium and whilst he had heard of it, his understanding of it at that time was not good. He explained that since this tragedy he has performed his own research on the topic and become more knowledgeable about same.

(121) Constable Warnock was referred to the Manual of Policy, Procedure and Guidance on Conflict Management and the Risk Factors associated with Positional Asphyxia. He accepted that the deceased met the majority of the risk factors listed and Sergeant Young's actions as regards using his own bodyweight on the upper body of the deceased was a concern as per the Policy Manual. As regards Excited Delirium he accepted that the deceased met some of the factors listed.

(122) At E 18 of that Manual under the heading "dealing with a Case of Excited Delirium" it states as follows:

"It is important to recognise the difference between Excited Delirium and a violent outburst. Once identified, there then lies the problem of how a person in an Excited Delirium state should be handled without endangering the public, the police officer, medical staff as well as the subject".

(123) Constable Warnock explained that it can be difficult on the ground to make this distinction.

(124) Once placed in the vehicle, Constable Warnock got into the front passenger seat and attempted to chat to the deceased in order to calm him down and to assess

what had happened. He accepted that there was a lot of confusion surrounding the matter and he was not really sure as to what to do.

(125) Constable Warnock described the deceased as being completely incomprehensible stating "don't shoot me, don't shoot me, I have kids."

(126) The deceased stated that his name was Mark James and that he was from the Ballygowan Road.

(127) Constable Warnock then exited the police vehicle and radioed Command and Control in an effort to try to establish who the deceased was. He stated that at this time he was still considering arrest or hospital.

(128) Pausing here I would refer to the entry in the Forensic Medical Officer's (FMO) Report as regards Constable Warnock which was made later that same day. It reads:

"There was never any question of him going to a custody suite - obvious on drugs - taken to hospital."

(129) This was information volunteered by Constable Warnock and recorded by the FMO.

(130) According to Constable Warnock the deceased attempted to escape from the police vehicle on at least one occasion although he conceded that he himself only witnessed one such attempt. He assisted Constable Willis when she shouted "guys help".

(131) The deceased was placed back in the rear of the police vehicle to the left and Constable Warnock sat in the rear beside him behind the driver. At no time up to this stage according to Constable Warnock, did the deceased lose consciousness. I refer again to FMO record where it states:

"was in back of car with DP (detained person) went quiet - couple of times".

(132) Constable Warnock explained that the deceased would speak and then go quiet but that he did not lose consciousness.

(133) It was at this stage that Constable Willis who was driving the police vehicle suggested that the deceased should be brought to hospital and Constable Warnock agreed with that assessment. Constable Warnock accepted that there was a lack of urgency in arriving at this decision, that there was confusion in the management of the situation and that there was a vacuum created once Sergeant Young had left the scene.

(134) According to Constable Warnock the deceased was positioned in an upright position and leaning against the front passenger seat/rear passenger door and his legs were across the back seat. He was talking to him as they left for Daisy Hill Hospital. Constable Warnock explained that the deceased was wriggling about and trying to bang his head of the door and that he, Constable Warnock, was on his hunkers at the deceased's feet watching the deceased. He accepted that the deceased's posture was less than optimum but that he felt that the deceased had got himself into a comfortable position and he did not want to aggravate him by moving him.

(135) Suddenly at Patrick Street the deceased's eyes started closing and he appeared to lose consciousness. The deceased's head and shoulders according to Constable Warnock were hanging over the seat towards the footwell. The deceased did not respond to Constable Warnock and he alerted Constable Willis who activated the siren and blue lights.

(136) Constable Warnock explained that due to the speed of travel he was trying to hold onto the deceased, that they were moving about but that he had no recollection of the deceased ending up in the footwell of the police vehicle although he was 100 percent sure that the deceased had not been placed into the footwell after he had struck his head off the pavement whenever the police vehicle had been parked in Bridge Street.

(137) Ms Patricia McGroder gave evidence to the Inquest. At the time she was a Staff Nurse at A&E department of Daisy Hill Hospital. At approximately 9am on 14tDecember 2015 a female police officer entered the department requesting help as

there was somebody unconscious in the police car. Ms McGroder and a Health Care Assistant went to the car which was parked directly outside the A&E department. Ms McGroder observed a male (the deceased) in an upright position in the passenger side foot-well in the rear of the car. His feet were across towards the driver's seat. He was not on the seat. A male police officer was attempting to get the deceased out of the car. According to Ms McGroder, the deceased was unconscious, very pale and his lips were blue. She did not notice any handcuffs or restraints on the deceased at that time. Ms McGroder went to summon more assistance and on return the deceased was out of the car and on the ground receiving CPR by, as I heard, Constable Patton.

(138) Ms McGroder stated that at some time between police entering the A&E department and the deceased coming into resuscitation, police informed her that the deceased was a known drug user and had been thrashing about through the police car but that around Patrick Street or Monaghan Street he became quiet in the car.

(139) On examination Ms McGroder noted a mark on the deceased's arm which he may have scaled off a fence.

(140) In his statement to the Inquest, admitted under Rule 17, Dr Charles McAllister stated that he first encountered the deceased at 5.24pm on 14 December 2015 in Craigavon Area Hospital having been transferred from Daisy Hill Hospital. He was profoundly acidotic with brain swelling and that despite maximal treatment in ICU the deceased did not respond and life was pronounced extinct at 3.31am on 15 December 2015 at Craigavon Area Hospital.

(141) Dr Nathaniel Carey, Consultant Forensic Pathologist, was retained on behalf of the next of kin as an expert. Dr Benjamin Swift, Consultant Forensic Pathologist, was retained on behalf of the PSNI as an expert. Dr James Lyness, State Pathologist for NI performed the autopsy of the deceased and provided a report on his findings. Drs Carey and Swift also provided reports.

(142) At my direction all three Pathologists discussed this matter together and produced an agreed position paper. They also had the opportunity to view the CCTV and hear the audio recordings in addition to reading the witness statements.

(143) All three pathologists agreed that the immediate cause of death was hypoxic-ischaemic brain injury resulting from a cardiac arrest. In addition, they were in agreement that following the onset of the cardiac arrest;

"the deceased's fate was effectively sealed; the chance that his condition could have been improved would be virtually zero".

(144) The Pathologists further agreed that the deceased's prognosis may have been improved with admission to hospital at any time prior to cardiac arrest and that the laceration of the left upper eyelid would have bled from the moment it occurred.

(145) The Pathologists then postulated a number of possible factors regarding the onset of the cardiac arrest, namely:

(146) Cocaine intoxication, restraint and/or struggling, post-exercise peril, postural asphyxia relating to the deceased's positioning whilst in the back of the police car, psychological effects of being detained in these circumstances, in particular fear.

(147) Of all these factors, the Pathologists stated that cocaine intoxication was "very likely a factor, and that the others are evidence dependant."

(148) In fact the Pathologists indicated that whilst it was not possible to determine the exact amount of cocaine consumed by the deceased his behaviour would not be typical of someone who had taken a small amount. Indeed, Dr Carey stated that his behaviour was that seen with individuals who had consumed crack cocaine.

(149) Dr Swift in particular was of the view that the longer in time between the restraint and the cardiac arrest then the less likely there was a causal connection between the two events.

(150) From the CCTV all three pathologists agreed that it was difficult to opine whether the deceased was conscious, unconscious or semi-conscious, following the restraint.

(151) As regards the actions of Sergeant Young, notwithstanding the bruising found to the deceased's back, none of the pathologists could determine that this bruising was directly attributable to Sergeant Young's actions of lying across the deceased's back with his back, particularly in light of the deceased's bizarre behaviour prior to the restraint.

(152) A toxicological analysis of a sample of the deceased's ante-mortem blood showed the presence of a number of drugs namely; benzoylecgonine (a breakdown product of cocaine). Its concentration was detected within the range reported in chronic cocaine users. Low levels of diazepam and fluoxetine were detected as well as lidocaine which is used as a cutting agent in illicitly produced cocaine.

(153) I find that by reference to the toxicological analysis and from the deceased's demeanour and behaviour he had consumed a significant quantity of drugs and that this was evident to all the civilians and some of the police who had encountered him that morning.

(154) I find that the two least experienced officers, Constables Hutchings and Patton, recognised this from very early on in attending the scene as did Constable (now Sergeant) Warnock but that the other attending police officers did not in a timely manner and that they should have recognised this and that following the initial restraint there was a significant delay in deciding to take him to hospital.

(155) I find that there was no risk assessment performed on arrival at the scene and no thought was given to the possibility that the deceased had been knocked down or was perhaps otherwise in a vulnerable state.

(156) I find that Constable Warnock had formed the view that the deceased was a suspected burglar who had already tried to evade capture and that this set the tone as to how he and his colleagues were going to deal with the situation.

(157) I further find that there was no attempt to talk with the deceased and that "excited delirium" was not considered by anyone at the scene. This is all the more striking given the clear guidance in their training and policy manual and given the reports of bizarre behaviour before contact with police, and his variant behaviour between resistance and calm. I find that excited delirium should have been at the forefront of the officers' minds on arrival to the scene. The idea of "containment" was not considered by any of the responding officers. I find that force was used to put the deceased to the ground prior to any resistance being offered.

(158) However, I find on the balance of probabilities, given the location and time of the morning, and the danger of the deceased being struck by a vehicle, restraining the deceased was appropriate both for his safety and the public's safety.

(159) I find that Constables Warnock and Braiden had the deceased "under control" prior to the involvement of Sergeant Young and that there was no need for Sergeant Young to have immediately, without pause, become involved in the restraint nor any of the other officers who attended.

(160) I find that what Sergeant Young told his counsellor on 8 November 2016 represents the accuracy of the matter, that is:

"Should have taken extra time to look and may have recognised signs of the young man's presentation". (161) I find that once the deceased was placed in handcuffs, he should have immediately been taken to his feet and the placing of limb restraints, and the manner in which this was done was unnecessary and inappropriate at that time. I find that at no time was the deceased physically aggressive or abusive to police. His shouting did not constitute in this context verbal aggression and in any event "verbals" did not pose a risk to any of the officers.

(162) I find that the deceased did not kick out at Constable Willis when in the rear of the police car as he was sitting upright bound with handcuffs to the rear with limb restraints applied above the knees and around the ankles.

(163) I find on the balance of probabilities that whilst he was not completely alert, the deceased was conscious when in the rear of the police vehicle, based on my listening to the radio communications and as evidenced by his expressed concerns to Constable Willis that someone was "going to get him", sentiments which other civilian witnesses stated the deceased had expressed to them. He was also able to provide part of his name, that is, "Mark James" to Constable Willis. However, I find that the deceased was likely starting to be slipping in and out of consciousness whilst in the rear of the police car.

(164) I find, on the balance of probabilities, that the deceased was not restrained by way of a seatbelt in the rear of the police vehicle.

(165) I find that his head did strike the footpath and scrape along the ground as it came out of the rear of the police vehicle. Although I find that this injury did not affect the outcome I find that at this stage having sustained a head injury and it being clear that the deceased was under the influence of something more than alcohol, the deceased should have immediately been taken to hospital by way of blue lights and siren. I have calculated from the CCTV that it was some 8 minutes 30 seconds after this event before the police car moved off from the scene.

(166) No police officer provided a satisfactory reason as to why there was a delay of some 8 minutes 30 seconds from the deceased first being placed in the vehicle to leaving the scene.

(167) I find, as conceded by Constable Warnock, that there was confusion around the management of the situation and a complete lack of urgency on the part of the officers once the deceased had initially been placed in the rear of the police vehicle.

(168) I find that it was obvious that the deceased was never going to a custody suite as expressed by Constable Warnock to the FMO.

(169) I find that once the officers had placed the deceased in the rear of the police vehicle it should have been obvious that this was a medical emergency and I find

that the delay in taking the deceased to hospital was unacceptable and represented a missed opportunity in respect of the care of the deceased.

(170) I find that once the deceased had suffered an out of hospital cardiac arrest then he was past the point of no return.

(171) The evidence suggests that there is a deficit in the training of police around the concept of "Excited Delirium". It appears that whilst this subject is covered in a Police Manual no processes exist to ensure that the said Police Manual is being digested and understood by officers. The evidence suggests that much more emphasis needs to be paid in training to this condition and that a video and Police Manual by themselves are not dealing effectively with same. The level of this police training is surprising to me as Coroner given the numbers of drug deaths in Northern Ireland. The fact that these situations are inevitably difficult for police to assess and manage only serve to highlight the importance of meaningful training for officers in this regard.

(172) The evidence further suggests that there needs to be a fresh approach to policing incidents such as this particularly given the number of drug and/or mental health related incidents.

(173) A post-mortem was performed, and it records and I find that death was due to:

I (a) Hypoxic Ischaemic Necrosis of Brain.

Following

Cardiac Arrest;

Due To;

(b) Cocaine Toxicity.

II Restraint, struggling, post-exercise peril, and psychological effects of being detained in the particular circumstances.