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CORONER FOR NORTHERN IRELAND

MR JOSEPH McCRISKEN

INQUEST INTO THE DEATH OF

GERARD McMAHON

FACTUAL FINDINGS

12 March 2021

Introduction

[1] This inquest investigated the death of Mr Gerard McMahon who died on 8 September 2016 in the Intensive Care Unit (ICU) of the Royal Victoria Hospital (RVH) Belfast. A number of hours prior to his death Mr McMahon was involved in an interaction involving physical restraint by Police Service of Northern Ireland (PSNI) Officers. Mr McMahon'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 February 2020 the Public Prosecution Service confirmed in writing that there would be no criminal prosecution of any PSNI Officers related to the death of Mr McMahon. Up to this point I had been prevented, pursuant to Rule 12 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 (the 1963 Rules) from proceeding to hold an inquest. I had, nonetheless, held a number of case management hearings to prevent undue delay in the holding of an inquest.

[2] I was represented by Coroners Counsel Mr Sean Doran QC and Mr Declan Quinn. My solicitor was Ms Dougan. Mr Arthur Harvey QC and Mr Stephen Toal appeared for the next of kin ('NOK') instructed by Mr Ó Muirigh, Solicitor. Ms Neasa Murnaghan QC and Mr John Rafferty appeared for the PSNI instructed by PSNI Legal Services and Mr Michael Egan and Mr Mark Mulholland QC appeared for Officer A, Officer B and Officer C instructed by Edwards & Co Solicitors.

[3] That we were able to hold this inquest during a worldwide pandemic is a testament to a huge team effort. I want to thank first and foremost my own legal team for their tireless dedication, effort and professionalism in preparing for this inquest. I also wish to thank the other legal teams for their assistance and for the collaborative and sensible approach that has been adopted throughout. I want to thank the PONI and those investigators who discharged their duty impeccably and to a very high standard. Finally, my thanks goes to those members of the Office of the Lord Chief Justice, Northern Ireland Court Service, Coroners Service and International Conference Centre who have worked diligently in preparation for and during this inquest. I am indebted to, in particular, William, Jordan, Claire, Darren and Linda, members of staff in the Coroners Service.

[4] I next want to formally recognise the patience and resilience of the extended McMahon family. They have waited too long for the findings which I am about to deliver, they have listened to the evidence with respect and have shown respect for this process. They are a model example of how to respect the Rule of Law. Despite their understandable frustrations they allowed those PONI investigators responsible for inquiring into Mr McMahon's death the time and space to do their jobs effectively.

[5] I want to thank Mr McMahon's young niece Abbie who wrote me a touching letter telling me about her uncle and the relationship she enjoyed with him and for reminding me of the responsibility I have, not just to provide answers in my role as an independent judicial officer, but also of the importance of those answers to a bereaved family.

The Inquest Hearing.

[6] This inquest commenced on 15 February 2021 and heard evidence over 8 days. During the inquest I heard oral evidence from 15 witnesses. 48 statements or reports were admitted pursuant to Rule 17 of the 1963 Rules. In total I have considered around 4,000 pages of evidence.

[7] In advance of the inquest hearing and by agreement with all Properly Interested Persons (PIP's) I granted anonymity to three PSNI Officers. They were anonymised as Officers A, B and C. I also allowed them to be screened from the public gallery and

permitted only named members of Mr McMahon's family to view them giving evidence. At this stage I want to thank all PIP's for adopting such a practical approach to anonymity and screening applications which undoubtedly saved time and expense.

[8] The inquest hearing proceeded in hybrid form, meaning that a mix of remote technology and live courtroom attendance was utilised. The case proceeded in a socially distanced 'Nightingale Court' in the International Conference Centre at Belfast Waterfront Hall, with solicitors, counsel and some next of kin present. I allowed others, including the media, to link in remotely.

Relevant law and approach to the conclusions.

[9] Rule 15 of the 1963 Rules governs the matters to which inquests shall be directed. This rule provides that:

> *"The proceedings and evidence of an inquest shall be directed solely to ascertaining the following matters, namely:*
>
> *(a) Who the deceased was;*
>
> *(b) How, when and where the deceased came by his death;*
>
> *(c) … The particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death."*

[10] Rule 16 goes on to provide that:

> *"Neither the Coroner nor the jury shall express any opinion on questions of civil or criminal liability …"*

[11] I indicated at an early stage in proceedings my view that my findings should comply with article 2 of the European Convention on Human Rights ('article 2 ECHR') so that the 'how' in Rule 15(2) must be interpreted as meaning 'by what means and in what circumstances' the deceased came by his death.

[12] What should be included in article 2 narrative findings? Narratives can include: 'causes of death, defects in the system which contributed to death and any other factors relevant to the circumstances of the death'. According to the Chief Coroners Guidance in England and Wales (which does not bind me in any way) a narrative finding must culminate in an expression of my conclusions on the 'central issues'. A coroner has a power in an article 2 inquest, but not a duty, to consider for the purposes of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death *(R (Lewis) v HM Coroner for the Mid and North Division of*

Shropshire [2010] 1 WLR 1836). A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in producing a report to prevent future deaths pursuant to Rule 23(2)(b) of the Coroners Rules. A conclusion in an article 2 inquest may be a 'judgmental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of death' while avoiding questions of civil or criminal liability.

[13] In accordance with *Jordan v United Kingdom (2001) EHRR 52* an inquest examining the use of force by State Agents, the police in this inquest, the process must be capable of determining whether the use of force was justified.

[14] The Chief Coroners Guidance (referred to above) suggests that permitted judgmental words include 'inadequate', 'inappropriate', 'insufficient', 'lacking', 'unsuitable', 'unsatisfactory', and 'failure'. On the other hand, words which suggest civil liability such as 'negligence', 'breach of duty', 'breach of article 2' and 'careless' are not permitted as they may breach the 1963 Rules.

[15] The correct standard of proof to be applied when considering any issue at inquest is the civil standard, the balance of probabilities and I must be satisfied that any act or omission caused or contributed in more than a minimal or negligible way to the death. In Northern Ireland, in inquests of this nature when art 2 ECHR is engaged, the civil standard of proof has been applied before verdicts have been reached. There are numerous reported cases in relation to this including the case of Jordan where the civil standard was discussed and approved by the Northern Ireland Court of Appeal, reported at [2018] NICA 34. The standard of proof to be applied in inquests has been the subject of litigation recently in England & Wales in a case heard by the Supreme Court, that of *R(On the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire [2020] UKSC 46* and in Northern Ireland In the *Matter of an Application by Hura Steponaviciene for Judicial Review* [2020] NICA 61.

Scope of Inquest

[16] It was agreed prior to the inquest commencing that proceedings will consider the four basic factual questions, as required by Rule 15 of the 1963 Rules, concerning:

(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.

[17] Related to the "how" question, it was agreed that the inquest would hear evidence in respect of the following, insofar as such evidence can reasonably assist in determining how the deceased came about his death:

i. the movement and conduct Mr McMahon from leaving his home on the evening of 7 September 2016 to the time of death on 8 September 2016;

ii. interaction between the deceased and members of the public and between Mr McMahon and officers of the Police Service for Northern Ireland (PSNI) during that period;

iii. the response of police to reports concerning the movement and conduct of Mr McMahon during the relevant period;

iv. the response of police and emergency medical services to the incident in which Mr McMahon required medical attention;

v. alcohol and toxicology analysis that was conducted to determine whether Mr McMahon may have been under the influence of alcohol and/or drugs at and prior to the time of death;

vi. pathology, encompassing an analysis of the multiple factors cited in the autopsy report as having contributed to the death.

[18] It was further agreed that the inquest's examination of the interaction between Mr McMahon and others during the relevant period shall include the following (in chronological sequence):

i. interaction between Mr McMahon and door staff at Thompson's Garage, Patterson's Place;

ii. interaction between Mr McMahon and members of the public at Upper Arthur Street;

iii. interaction between Mr McMahon and members of the public in the vicinity of the City Hall;

iv. interaction between Mr McMahon and members of the public at Friendly Way;

v. interaction between Mr McMahon and taxi staff in the vicinity of the Europa Hotel, Great Victoria Street;

vi. interaction between Mr McMahon and officers of PSNI in Great Victoria Street.

[19] It was also agreed that my examination of the interaction between Mr McMahon and officers of the PSNI should include, to the extent that is necessary to enable me to determine how the deceased came about his death, a consideration of the officers' training and instruction on the matter of restraint and any relevant PSNI policy and practice governing that matter.

Narrative Findings.

Background

[20] Mrs Ella McMahon, Mr Gerard McMahon's mother, told the inquest that Mr McMahon was a very caring person who provided great support to her at home. He was well liked within the family group. Mr McMahon was employed in various jobs from a young age. He became interested in music and went on to work as a Disc Jockey (DJ) in local nightclubs, known as DJ Macko, and appears to have been talented in that regard.

[21] In relation to Mr McMahon's drug use, Mrs McMahon told the inquest that she knew Mr McMahon was struggling with addiction issues for a number of years. She said he had been attending Narcotics Anonymous to try and receive assistance with his drug problem. Mrs Ella McMahon appeared to me as a mother who was well of her son's issues and as someone who had tried her very best to assist him. She is clearly a woman of considerable strength and personal resilience.

[22] General Practitioner (GP) notes for Mr Mahon show he was a cigarette smoker of 20 a day for over 10 years. It is recorded that he had been assaulted on several occasions. On 25 September 2005 he was assaulted by five people. Subsequently, he was admitted to Daisy Hill Hospital in Newry on 8 November 2015 having been assaulted and sustained a head injury. Notes from this incident record that on arrival at hospital Mr McMahon may have been under the influence of drugs and was behaving in a sexualised manner. There are several other assaults and injuries recorded. Mrs Ella McMahon, Mr McMahon's mother, told me at inquest that she suspects Mr McMahon started drugs around the middle of 2015 possibly following an assault. Mrs McMahon told the inquest that when he was taking drugs his behaviour was affected adversely

and he would have no memory of his behaviour when on drugs. She said he would often consume alcohol when taking cocaine.

[23] The medical notes suggest that Mr McMahon had a cocaine use disorder and when taking cocaine and alcohol this gave rise to acutely disturbed behaviour. He received medical treatment in hospital for this in the past. Mr McMahon discussed drug taking with his GP in May 2016 and told his GP he was taking 1g of cocaine on a Saturday evening. He told his GP he started drugs after being stabbed, but was not suicidal and he said he wanted to stop drugs. Mr McMahon was referred by his GP to the Community Addiction Team around June 2016 and offered an appointment for September 2016. He died before he could attend this appointment.

[24] I am satisfied that Mr McMahon was abusing the illicit class A drug cocaine for a number of years before his death. It seems to me that he was probably abusing cocaine recreationally for a time prior to the assault in Newry in 2015, since on admission to hospital following this assault he was noted to be under the influence of drugs and was displaying sexualised behaviour. Despite seeking out assistance, attending Narcotics Anonymous and receiving a referral to the Community Addiction Service Mr McMahon continued to abuse cocaine.

Events of 7 and 8 September 2016.

Thompsons Garage

[25] I have arrived at the following factual findings having reviewed and considered oral evidence from witnesses, statements from witnesses admitted under Rule 17 and Closed Circuit Television ('CCTV') footage from a number of locations in and around Belfast City Centre. Any timings provided based upon CCTV footage are likely to be approximate.

[26] On Wednesday 7th September 2016 Mr McMahon was at home with his mother, with whom he lived with. Mrs McMahon told the inquest that although he appeared quite normal she thought he seemed quieter than usual. At 10.45pm a friend called and they went by taxi to a nightclub in Tomb Street, Belfast. At around 11.50pm Mr McMahon went to Thompsons Garage nightclub in Belfast City Centre along with three males.

[27] CCTV footage from inside Thompsons Garage nightclub was examined by PONI investigators, although this was not played during the inquest. This footage records Mr McMahon arriving at the club at 11.51pm with three other males. During the course

of the next two hours or so Mr McMahon and members of his party can be seen to place substances into their nostrils. I am satisfied that Mr McMahon and the other individuals were ingesting cocaine. Mr McMahon can also be seen to consume alcohol.

[28] Later that evening it was reported that Mr McMahon exposed himself on the dance floor of the nightclub. Although this incident was not recorded on CCTV the aftermath was captured. This behaviour was witnessed by persons inside the club and reported to security staff. At around 2.00am on Thursday 8th September, following on from his behaviour, Mr McMahon was involved in a physical struggle with another male on the stairs in the nightclub. Club security staff escorted Mr McMahon off the premises, he was noted to be intoxicated at the time. He can also be seen to have his trousers loosened at the belt and his hand was placed directly down the front of his trousers.

[29] I am satisfied that Mr McMahon behaved as described by other persons in the nightclub and that this behaviour was due to the ingestion of cocaine and alcohol. Mr McMahon had displayed sexualised behaviour on previous occasions when under the influence of drugs and/or alcohol.

[30] Once Mr McMahon was taken to the alleyway outside the nightclub he placed his hand down the front of his trousers and remonstrated with five members of the security staff. CCTV footage from the alleyway was viewed during the inquest. It shows Mr McMahon interacting with the security staff. Although no audio is available it seems that Mr McMahon is speaking aggressively to the security staff. Statements were read from the security staff at inquest. They indicated that Mr McMahon was verbally abusive to them. At no time did the security staff show any aggression toward Mr McMahon despite the very obvious goading. After a few minutes Mr McMahon moved aggressively towards one of the security staff and was pushed back with one hand, he then aimed a punch at the same member of security staff and he was forced to the ground. CCTV is not entirely clear but it appears that Mr McMahon was restrained on the ground by security staff for approximately 2 minutes. In their statements to the inquest the security staff recalled that Mr McMahon was restrained on the ground until he agreed he would be calm. Once he agreed he was allowed up to his feet and made his way towards Upper Arthur Street. At 2.07am CCTV showed Mr McMahon being assisted away from the alleyway by two members of the public.

[31] I am satisfied that the force used by the security staff was reasonable in all the circumstances. Although Mr McMahon was forced to the ground by security staff this was in direct response to Mr McMahon attempting to strike one of them. He was only held for a short period and then released. Mr McMahon did not appear unduly affected by this interaction, however, some of his behaviour in the alleyway could be described

as strange or bizarre. This included lying down on a road surface which was clearly soaking wet and interacting with other patrons who did not appear to appreciate his attention. He did appear to be heavily under the influence of drugs and/or alcohol.

Upper Arthur Street

[32] Shortly after leaving the alleyway Mr McMahon entered Upper Arthur Street. At 2.14am he sat or fell onto the bonnet of a parked Nissan Micra car and fell backwards hitting his head on the windscreen. Members of the public helped him off the car. He was subsequently noted to be staggering. I was able to watch CCTV footage of this incident and statements were read from those members of the public who were involved. Although we explored at inquest the issue as to whether any of the members of the public kicked Mr McMahon I do not consider that Mr McMahon suffered any serious injuries during this interaction.

City Hall

[33] At 2.30am Mr McMahon was seen in Donegal Square South on the footpath outside Ten Square Hotel. CCTV footage showed him falling heavily through a glass partition outside the hotel, smashing it. The footage showed him to be unsteady on his feet and his trousers were down round his ankles exposing his genitals at times. He was carrying an object of unknown origin at this time. He was stumbling and fell many times including into a metal bin and onto an advertising sign. Between 2.47am and 2.53am three members of the public reported observing a man believed to be Mr McMahon clothed in a blue T-shirt with his trousers and boxer shorts round his ankles lying on the ground in the proximity of the Belfast City Hall shouting and screaming. A number of members of the public went to assist Mr McMahon but it appears he was too intoxicated and too aggressive to accept assistance. At one stage Mr McMahon appeared to drink from a puddle on the ground.

[34] A taxi driver, who was on duty, noticed Mr McMahon at the back of the City Hall. He was dressed in only his underwear which was down around his ankles. He had injuries to his legs. This taxi driver drove to Grosvenor Road police station and alerted an employee in the sangar to the situation with Mr McMahon at the back of the City Hall. This taxi driver then drove back round to the City Hall and witnessed Mr McMahon putting his trousers into a bin.

[35] A number of calls were made to police reporting the behaviour of Mr McMahon. An initial call was made at 2.47am with further calls at 2.53am and 2.56am. These calls were categorised as priority calls rather than emergency calls. A police patrol was

tasked to the area arriving at 3.36am. I was told at inquest that this was a busy night and this was the first available patrol. Police officers spoke to workmen near the City Hall who informed that the male had left the area around 20 minutes before police arrival. The incident was closed at 3.40am. The call handlers did not utilise the City Centre CCTV cameras at any time. Footage shown at inquest was recovered after death by PONI investigators from private buildings.

Markets Area

[36] Between 3.00am and 3.50am CCTV cameras recorded Mr. McMahon walking towards the Markets area of Belfast. Witnesses reported him being present in and around the area of Friendly Street shouting and singing. Sometime between 3.30am and 4.30am a resident of Friendly Way was awoken by a male shouting outside his house. He saw a man wearing a blue coloured T-Shirt and boxer shorts close to a bike and wearing a traffic cone on his head. When the resident went outside and confronted the male a scuffle ensued and the male fell to the ground after being grabbed by the neck. This male then made off toward the City Centre. The resident described him as being completely 'out of it' and making no sense. I am satisfied that this male was Mr McMahon. It is not possible for me to be sure if any injuries were caused as a result of the altercation.

[37] Mr McMahon then made his way back to the City Centre and at around 4.32am was seen to be tying his T-shirt to a set of railings. At about 4.35am he was recorded on a bicycle in Franklin Street heading towards the Ulster Hall. He then got off the bicycle and continued on foot.

Great Victoria Street

[38] Just before 4.45am Mr McMahon used a street sign to smash the window of a Belfast City Council van which was parked in the street. He then used another road sign and used it to strike a taxi. Two taxi drivers, including the taxi driver who had reported Mr McMahon to police earlier, became involved in an altercation with Mr McMahon after Mr McMahon struck one of the taxi drivers. A second taxi driver then ran towards Mr McMahon and kicked him in the buttock region before a number of punches were exchanged. Mr. McMahon then ran towards the first taxi driver as he was attempting to pick up the road sign, but was tripped/kicked by the second taxi driver. He subsequently fell to the ground onto his left side and got up and walked away in the direction of the back of the Crown Public House. At this stage he was dressed only in his boxer shorts.

[39] One of the taxi drivers entered the lobby of the Europa Hotel and asked that the receptionist call the police. At around 4.45am Philip Murphy, the night manager of the Europa Hotel, Great Victoria Street, Belfast contacted police to report a man throwing a road sign towards a parked taxi near the Hotel.

[40] CCTV played at inquest demonstrated that Mr McMahon walked along Amelia Street, turned left onto Brunswick Street. He was noted by Mr Colm McMahon (following at a distance) to be walking on the road rather than the pavement. Mr McMahon continued to Howard Street and eventually entered Great Victoria Street. Mr Murphy, who was following at a distance behind Mr Colm McMahon, gave evidence that he was concerned about Mr McMahon's behaviour and was, in fact, on the telephone to police during this period.

[41] CCTV then showed Mr McMahon crossing Great Victoria Street and standing on the pavement waving his hands above his head, turning around as if looking for someone. Cars passed, the road was otherwise deserted and Mr McMahon moved about on the road and pavement waving hands above his head in an aimless manner. At 4.49am two PSNI officers crossed the road towards Mr. McMahon.

The Restraint

[42] The interaction between Mr McMahon and police was captured on city centre CCTV. I also heard oral evidence from Officers A, B and C as well as Mr Philip Murphy in relation to the interaction and the restraint. A number of statements of eye witnesses to these events were admitted under Rule 17 of the 1963 Rules.

[43] Giving evidence Officer A, who had just over 5 years' experience as a police officer, said that it had been a busy night. He and Officer C, a probationary officer (less than 2 years' service), who was the observer, were on their way back from attending a call in East Belfast when they got a transmission asking them to attend at Great Victoria Street. They were told that a male, later identified to them as Mr McMahon, had been fighting with taxi drivers at that location. They were also told that the male was dressed only in his boxer shorts. He was aware that there had been previous calls regarding the same male. On the way to the call he was informed by the City Centre CCTV operators that there was an ongoing fight between the male and some taxi drivers. As his patrol turned into Great Victoria Street he saw a male dressed in his boxer shorts walking up the middle of the road with his arms outstretched. This male was shouting.

[44] Officers A and C approached Mr McMahon and moved him off the road onto the pavement. Both Officers told the inquest that at this time Mr McMahon did not seem keen to move and tried to brush their hands off him as they moved him onto the

pavement. Officer A told the inquest that upon approaching this male he seemed quite aggressive. He was shouting things about bombs. Officer A noted that the male had cuts to a number of areas of his body, in particular one of his knees. Officer A took out his CS Incapacitant Spray ('CS') and pointed it toward the male while he issued commands that the male should get on the ground.

[45] For about 30 seconds both officers spoke to Mr McMahon but then completely out of the blue and without any contact between Mr McMahon and the officers, Mr McMahon fell backwards. He fell straight back onto the road without warning and quite spontaneously. His legs came up in the air and he landed onto his upper back and neck before he came to a rest flat on his back. CCTV footage depicts this as an exaggerated fall. Although Mr McMahon appeared to strike the ground hard with his back and in particular the heels of his feet he does not appear to acknowledge any pain. It appears that Mr McMahon did not strike his head at this point or at least did not do so with any appreciable force.

[46] Mr Philip Murphy told the inquest that he witnessed police officers initially speaking to Mr McMahon. He described this interaction as professional and described the officers as behaving in a relatively calm manner. He heard them tell Mr McMahon to "calm down" and "get on the ground". As Mr McMahon came closer to the officers they again repeated that he should "get onto the ground" and "not come any closer". Mr Murphy saw Mr McMahon fall to the ground. Mr McMahon told the officers they "shouldn't have done that" and according to Mr Murphy he began to "rant and rave again."

[47] While Mr McMahon was on his back, Officer C, assisted by Officer A, applied handcuffs to his wrists at the front. No force was required to apply the handcuffs and Mr McMahon did not resist. This was an issue explored during the inquest upon which I will comment later. Officer C told the inquest that he applied handcuffs because he feared, given what had been reported to him regarding fighting and criminal damage, that Mr McMahon might become aggressive. He placed the handcuffs on Mr McMahon for his own safety and that of the officers. Officer C accepted that he was trained to normally apply handcuffs to the rear but police are permitted to apply handcuffs to the front in certain circumstances. Officer C told the inquest that he considered the application of handcuffs to the front a reasonable way to deal with the immediate and future risk posed by Mr McMahon.

[48] Officer A told the inquest that the handcuffs were applied to the front because of the potential risk posed by Mr McMahon. He said that handcuffs were not applied to the rear because in his opinion this would have been uncomfortable. Once the handcuffs were in place he said no consideration was given to removing them and

re-applying to the rear. Both officers confirmed that they did not discuss the application of the handcuffs before, during or after they were applied.

[49] Officer B, who was part of the second 'back-up' patrol with Constable Walker, told the inquest that he had reservations about the application of handcuffs to the front. He said that it was his practice to apply handcuffs to the rear. Despite his reservations he did not communicate his concerns to Officers A or C.

[50] Both Officers A and C spoke to Mr McMahon as he lay on his back with the handcuffs in place. Officers A and C also referred to their opinion that to apply the handcuffs to the rear (or changing the cuffs from the front to the rear) would have involved placing Mr McMahon face down on the road (although at the time the handcuffs were applied Mr McMahon was sitting up).

[51] They then assisted Mr McMahon to his feet. At this stage, around 4.45am, another police patrol arrived with an additional two officers, Officer B and Constable Walker. Officer B had almost 10 years' service at this stage. All four officers walked Mr McMahon over to the pavement just outside the Grand Opera House. Mr McMahon was noted by all the officers to be unsteady on his feet. He was placed onto a small step at the corner of the Grand Opera House and remained sitting easily against the wall of the Opera House while the officers spoke to him. Officer B suggested that the location of the steps offered some shelter.

[52] At this stage two Officers left the scene. Officer C told the inquest that he went to make enquiries with the taxi drivers regarding the allegations of assault and criminal damage. Constable Walker was tasked to go to Lisburn Road PSNI Station and secure the use of a police cellular van. A decision had been taken to remove Mr Mahon from the scene. Officer A told the inquest he thought Mr McMahon would be taken to the nearby custody suite at Musgrave Station where a Forensic Medical Officer would treat and assess him. Officer B told the inquest that he thought Mr McMahon was likely going to be taken by police to hospital. There was no conversation about this between the officers.

[53] An ambulance was not called. Officers A and B told the inquest that an ambulance was not thought as being appropriate. There was some discussion at inquest regarding the use of the cellular van instead of placing Mr McMahon in a police car. This decision perhaps caused some delay in removing Mr McMahon from the scene. Officer B thought a cellular van would be appropriate given Mr McMahon's presentation. He thought he would contaminate the police vehicle since he was wet and bleeding. Officer B also thought that a police car would be too small should Mr McMahon become aggressive.

[54] Officers A and B tried to communicate with Mr McMahon but they were not able to ascertain any personal details. Both told the inquest that although Mr McMahon was not initially aggressive, he was not helpful. When he spoke he did not make sense and then became verbally abusive, particularly to Officer B.

[55] There was some divergence in oral evidence between the Officers as to Mr McMahon's demeanour at the steps of the Opera House. While Officer B said that Mr McMahon was verbally abusive, this was not the evidence of the other Officers who referred to Mr McMahon joking on occasion.

[56] As Officers A and B spoke to Mr McMahon he moved in an attempt to stand up. Officer A took hold of his shoulder and upper body while Officer B swept Mr McMahon's right foot. The result was that Mr McMahon returned to a seated position. Officer A maintained a hold on Mr McMahon's left shoulder. Constable C told the inquest that he heard a commotion and returned to assist his colleagues. At this stage Officer B was standing to Mr McMahon's right and in front of him . Officer A was to Mr McMahon's left side, holding his shoulder. Officer B and A maintained some downforce on Mr McMahon to try and keep him seated.

[57] Mr McMahon then made a more determined effort to stand and all officers pushed down on him to maintain a seated position. This developed into a struggle between Mr McMahon and all three officers. They managed to get him back down and into a lying position on the ground. I have watched the CCTV of this incident footage many times. It is unclear as to whether the officers deliberately took Mr McMahon to the ground at this stage or if he fell or forced his way to the ground.

[58] Officer A can be seen on CCTV footage to pull Mr McMahon to his (McMahon's) left and went to the ground with Mr McMahon. Mr McMahon landed on his front and was able to raise his chest off the ground on his elbows while Officer C held, or pulled, his legs out straight. Officers B and A tried to gain control of McMahon's upper body as he struggled fiercely with them. Mr McMahon was able to utilise his hands to push off the ground because he was not handcuffed to the rear.

[59] Mr McMahon then managed to roll to his left and the officers lost control for a moment as they grappled with him to contain the situation. The officers struggled to contain Mr McMahon. Mr McMahon got into a crouching position and appeared to attempt to stand.

[60] As the struggle continued Officer A took the decision to discharge his CS spray at close proximity, perhaps less than a metre, and in the direction of Mr McMahon's face. This initially appeared to make no difference to Mr McMahon who continued to struggle forwards but then slumped backwards. Mr McMahon almost managed to rise up onto his feet again. It took all three officers working hard to control Mr McMahon and get him onto his front on the ground.

[61] Mr McMahon appeared a little more subdued once he was placed onto his front. Officer A told the inquest that despite this he still required considerable force to keep Mr McMahon on the ground and he was still struggling against the officers. Officer B described to the inquest the force used by Mr McMahon as 'superhuman'.

[62] While Officer B was positioned on or around the rear of Mr McMahon's left shoulder, Officer A was positioned on or around his right shoulder. Officer C was trying to get Mr McMahon's ankles and legs straight and constrained and to do so he received help from Mr Murphy, the Night Manager of the Europa Hotel. Mr Murphy told the inquest he was asked to help by one of the officers. Indeed, one of officers suggested that Mr Murphy offered to help. He went across and removed the leg restraints from Officer C's utility belt. He then assisted as Officer C applied the leg restraints.

[63] At this point, 12.31 on the CCTV, Officer B placed a knee on the back of Mr. McMahon's left renal angle. Officer B in evidence said he placed his knee on Mr McMahon's left shoulder with his hands holding Mr McMahon's shoulders so as to lend body weight to keeping Mr McMahon constrained. Officer A was holding Mr McMahon's right arm and shoulder while the third Officer was holding his legs straight out and under control. Officer C told the inquest he had to push down hard to maintain control of Mr McMahon's legs.

[64] At this stage of the restraint Officer B released his right knee from Mr McMahon's back and appeared to place his head next to McMahon's head. It appears that he is checking on Mr McMahon's welfare. It seems that Mr McMahon is no longer struggling or moving. He was moved to his right side into a partial recovery position. A police patrol from Tennant Street then arrived at the scene. Officers A, B and C released their control and turned Mr. McMahon onto his right side. Mr McMahon was motionless at this point.

[65] I was told at inquest that Officer B checked if Mr McMahon was breathing at this stage. Officer B indicated that he wasn't sure and there was concern for Mr McMahon's wellbeing. One of the police officers called over to Mr Murphy to get a defibrillator

from the Europa Hotel. Mr Murphy ran to the hotel and arrived back with the defibrillator a short time later.

[66] Constable Gordon and Constable Kingsberry, the patrol from Tennant Street, attended Great Victoria Street after they heard radio transmissions. Constable Gordon told the inquest that on arrival he observed a male on the ground, handcuffed to the front with limb restraints on his legs. He said there were three officers around him controlling him. Constable Gordon said at this time the male was not moving or making any noise. He thought the male was breathing but was not responsive so he asked that an ambulance be tasked using his police radio. Constable Gordon said that although the male was in the recovery position his lips appeared blue. He ordered the handcuffs and limb restraints be removed. When the male was moved onto his back it did not appear he was breathing. Constable Gordon removed a police defibrillator and began preparations for Cardiopulmonary Resuscitation (CPR) by applying the defibrillator. No-one was performing chest compressions at this time. The defibrillator advised that no shock be applied and Constable Gordon then commenced chest compressions. Another police colleague performed rescue breaths until an ambulance arrived.

[67] Officer B told the inquest that he had been adversely affected by CS Spray and was struggling to see and breathe. For this reason he could not assist with CPR. Officer C was also affected by CS Spray and was struggling to breathe.

[68] Sergeant Robin Tudge was acting as Duty Sergeant at Lisburn Road PSNI Station on 8th September 2016. Sgt Tudge told the inquest he was in his office when he overheard a radio transmission regarding a male having caused criminal damage in Great Victoria Street. A crew were dispatched and Sgt Tudge directed that a second 'back-up' crew be sent. He the overheard a request for an ambulance. At this stage Sgt Tudge decided to attend the scene and travelled there in a matter of minutes in a police vehicle. He told the inquest he arrived around the same time as the ambulance. Sgt Tudge attempted to ascertain what had occurred and began to issue directions to officers regarding road closures, witness statements and gathering of evidence. Sgt Tudge said he could see that Officers B and C had been adversely affected by CS Spray.

[69] An ambulance arrived on the scene at 5.08am, approximately 5 minutes after being called. The paramedic who treated Mr McMahon gave evidence at the inquest. He said when he arrived effective CPR was being performed by police officers. He began to assess Mr McMahon and recorded that he was asystolic, his heart had stopped and there was no electrical activity within the heart. The paramedic administered adrenaline injections using an intraosseous needle. After approximately 20 minutes pulseless ventricular tachycardia, a shockable rhythm was recorded and almost instantaneously return of spontaneous circulation with a blood pressure (BP) recorded twice as 144/88

and 72/52. However, the paramedic noted that Mr McMahon's pupils were fixed and dilated, a sign of brain death and he was not breathing spontaneously. Mr McMahon was taken to the Emergency Department ('ED') of the Royal Victoria Hospital ('RVH') by ambulance.

[70] A clinical summary written by Dr McCarroll (ICU Consultant) admitted in evidence at inquest, described how Mr McMahon had suffered an out of hospital cardiac arrest with an estimated period of 15 minutes without cardiac output. On arrival Mr McMahon had return of spontaneous circulation but remained in respiratory arrest.

[71] Blood gas gave a blood pH of <6.8, slow pulse, low BP and mottled. Computed Tomography ('CT') brain showed changes of hypoxic injury, Mr McMahon had multiple rib fractures and no abdominal visceral damage. Glasgow Coma Scale, a measure of consciousness, was 3/15. Mr McMahon developed multiple organ failure, severe coagulopathy, remained profoundly hemodynamically unstable, had an acute kidney injury, an elevated Creatinine Kinase level (7523 – a significantly elevated value and a measure of skeletal muscle damage), urine toxicology showed the presence of cocaine. A urine sample submitted on the 8 September 2016 at 11.50am from Mr. McMahon detected cocaine, benzoylecgonine (a metabolite of cocaine) and lidocaine. Blood alcohol was measured at 481 mg/L. The test for heart muscle damage called Troponin T was not reportable.

[72] Despite intense treatment Mr McMahon passed away at 7.40pm on 8 September 2016 with his family at his bed side.

Post Mortem Examination

[73] Mr McMahon's death was correctly reported to myself, as Duty Coroner and to the Police Ombudsman (PONI). I ordered that a post-mortem examination be carried out by the State Pathologist for Northern Ireland Dr James Lyness. (In 2016 he was the Deputy State Pathologist).

[74] I intend rehearsing in some detail the post-mortem findings since there was intense discussion regarding the cause of death during the inquest.

[75] Mr McMahon's weight was recorded at 110 kg and his height was 178 cm. This resulted in a Body Mass Index (BMI) of 34.7. An individual with a BMI greater than 30 is recognised as obese.

[76] A number of injuries were noted by Dr Lyness:

Face / Head *14 areas of external blunt force injury 5 areas of deep bruising of scalp, 3 areas of deep bruising of the face 3 areas of bruising to the tongue*

Neck *3 areas of external blunt force injury 14 areas of deep bruising, fracture of the right superior horn of the thyroid cartilage*

Chest *3 areas of external blunt force injury (+ area of early decomposition) 5 areas of deep bruising, fractures of anterior 3rd – 8th left ribs Fracture of anterior right 3rd rib Fractures of lateral 3rd – 8th right ribs*

Back *7 areas of external blunt force injury 10 areas of deep bruising*

Abdomen *6 areas of external blunt force injury 2 areas of deep bruising in groins 1 area of deep bruising left lower quadrant Left arm 12 areas of external blunt force injury, 6 areas of deep bruising*

Right Arm *16 areas of external blunt force injury 4 areas of deep bruising*

Left leg *7 areas of external blunt force injury 13 areas of deep bruising*

Right leg *12 areas of external blunt force injury 8 areas of deep bruising*

[77] Dr Lyness reported that, while many of the external injuries were non-specific small bruises and abrasions, several larger areas of deep bruising to the neck, chest, back, legs and arms were noted.

[78] The major internal organs were essentially normal although significant gaseous decomposition was reported in the spleen and liver. The heart (388g) was not enlarged for his weight but some atheroma was noted in one of the three coronary arteries.

[79] Microscopic examination of the organs was performed which showed:

i. moderate (60%) coronary atheroma
ii. focal myocyte hypertrophy
iii. focal cytoplasmic banding (?contraction band necrosis)
iv. bilateral pneumonia
v. no pulmonary emboli
vi. mild hepatic fatty change
vii. widespread renal tubular necrosis / autolysis devoid of inflammatory cells
viii. myoglobin within tubules

[80] The brain was examined by Dr Herron, Consultant Neuropathologist, who recorded that the brain was swollen and pale but that there was no evidence of trauma,

infection or natural disease. He concluded that the features were those of swelling (oedema) and global cerebral perfusion failure.

[81] In his report, finalised in 2017, Dr Lyness opined that physical restraint of the type described by the police officers may interfere with an individual's ability to breathe and this could be exacerbated when prolonged pressure is applied to the trunk and the individual is lying face down.

[82] Furthermore, in obese individuals, such as Mr McMahon, breathing difficulties may be exacerbated by upward pressure from the abdominal cavity onto the diaphragm. Under such circumstances a cardio-respiratory arrest may occur and this may not be associated with any signs of external injury or the typical autopsy findings seen in other forms of asphyxia-related death. Dr Lyness considered that although there is a temporal relationship between Mr McMahon being restrained and his cardiac arrest there are other factors that need to be considered in relation to the acute deterioration in his condition.

[83] Dr Lyness was able to examine witness statements and available CCTV footage. He thought Mr McMahon's behaviour demonstrated some form of Acute Behavioural Disturbance (ABD), characterised by erratic, often combative, behaviour, inappropriate shouting and disrobing. Such incidences, opined Dr Lyness, are commonly associated with underlying psychiatric disease or the effects of psychoactive substances, including some drugs of abuse and pharmaceutical medications. The collection of symptoms is often referred to as 'excited delirium' and, in some cases, the associated extreme physiological and psychological strain placed on the body can precipitate a cardiorespiratory arrest and death. Furthermore, those individuals who make it to hospital often succumb to terminal events such as a type of coagulopathy, known as disseminated intravascular coagulation, kidney failure secondary to the breakdown of muscle, known as rhabdomyolysis, pneumonia and/or irreversible brain damage. He told the inquest it is also well recognised that restraint, of any form, of individuals suffering an ABD will increase the psychological and physical strain on the body, further increasing the risk of a cardiac arrest and death. This could also be augmented by the use of CS spray.

[84] In Dr Lyness' opinion there is little doubt that the ABD was due to Mr McMahon having taken the commonly abused stimulant drug cocaine. Analysis of a sample of blood taken shortly after admission to hospital revealed a low level of cocaine, and the presence of this drug indicated his relatively recent use of cocaine prior to the sample being taken, as the drug is rapidly broken down in the body and is generally only detectable for between four and twelve hours after its usage. In contrast, a relatively high concentration of the main breakdown product of cocaine, known as benzoylecgonine, was detected and this may be indicative of binge use of the drug during the hours prior to his admission to hospital. Consequently the concentration of

cocaine in the bloodstream would have undoubtedly been higher during this time, including during his restraint by police officers. Indeed, Dr Lyness commented that it is well recognised that the effects of cocaine are unpredictable and may precipitate death, at any time, commonly from either a sudden disturbance in the heart rhythm or an epileptic type seizure.

[85] Analysis of a blood sample by a forensic scientist indicated that at the time of the incident Mr McMahon would likely have had a blood alcohol concentration of approximately 55mg per 100ml. This is below the drink drive limit of 80mg per 100ml. Analysis of a sample of ante-mortem blood, taken at 9.30am on 8 September 2016, while Mr McMahon was being treated in the ED, revealed that in the hours before his death Mr McMahon had consumed cocaine. The drug cocaethylene, formed when cocaine is taken in conjunction with alcohol, was also discovered.

[86] There were a large number of injuries on the external surfaces of the body, including the scalp, face, neck, chest, abdomen, back and all four limbs. The vast majority of these were relatively non-specific and could have occurred as a result of the multiple falls and collapse episodes he is believed to have suffered, whilst he was rolling and crawling about on the ground, during any of the alleged and witnessed physical altercations, during his restraint by the police officers or, in some instances, medical treatment.

[87] Dissection of the neck, chest, abdomen, back and limbs also revealed multiple areas of bruising within the underlying subcutaneous tissues and muscles. Whilst such deep bruising is indicative of a moderate to severe degree of force, it would seem reasonable to suggest that both this deep bruising and the surface injuries may have been exacerbated and intensified by any alteration in blood clotting secondary to the coagulopathy diagnosed following his admission to hospital. There was also early decomposition of the body and this too caused difficulties in the accurate assessment of some of the injuries.

[88] There were numerous relatively minor abrasions and bruises, and a single superficial laceration, on the face. There was also bruising of the undersurface of the scalp, consistent with his having suffered blunt impacts of the head. However, there were no differentiating features to state how these injuries had been sustained.

[89] Regardless of their exact aetiology the injuries were not associated with a fracture of the underlying skull, and a detailed examination of the brain, by a neuropathologist, excluded the presence of a traumatic brain injury. Indeed there was no evidence to suggest that a head injury had played any part in his death.

[90] There was purple discolouration of the sides of the neck, and, whilst this may have been exacerbated by the effects of decomposition, at least some areas were

probably representative of bruising. In addition, there were two bands of bruising on the front of the neck, suggestive of an object with a straight edge having come in contact with this region or the body, possibly clothing, but there were no other distinguishing features to indicate exactly how these had occurred. Subsequent dissection revealed multiple bruises within the neck muscles. Whilst some of these may have been caused during resuscitation and medical treatment, such as those on the right side of the neck in proximity of a needle puncture wound, others were undoubtedly the result of blunt trauma. Indeed the presence of a fracture of one of the delicate cartilages of the voicebox would support that his neck may have been forcibly grasped at some point prior to his death. There were also a small number of pin-sized haemorrhages within the linings of the eyelids, and these too can be associated with neck compression. However, their relative paucity would not suggest that his neck had been compressed for a prolonged period of time. Furthermore, such petechial haemorrhages can occur for a number of other reasons, including secondary to prolonged heavy pressure applied to the trunk or as a result of a cardiac arrest. It is therefore not possible to state, from the autopsy findings alone, at what point the neck compression occurred nor the relative extent, if any, it may have played in the fatal sequence.

[91] In the chest and abdomen there were multiple non-specific surface bruises and areas of deep bruising.

[92] There were also fractures of six of the left ribs and one of the right ribs towards the front of the chest cage, and six of the right ribs towards the side of the chest cage. Dr Lyness considered that such injuries could have been the result of falls or collapse episodes, blunt blows, such as punches or kicks, or heavy compression of the chest. However, he said it is also well recognised that fractures towards the front of the chest cage are commonly caused by chest compressions during resuscitation attempts. It is therefore extremely difficult to be certain as to when each of the rib fractures occurred. Despite this it would seem reasonable to conclude that once the ribs were fractured the osseous injuries would have decreased his ability to breathe.

[93] On the back there were numerous surface bruises and those on the outer sides of the lower back and buttocks were associated with multiple abrasions and superficial lacerations, suggestive of having been the result of falls and collapse episodes onto, or heavy contact with, a hard surface, as well as semi-sharp objects, possibly shattered glass. A vaguely patterned bruise on the left side of the lower back contained limited detail to accurately establish how it was sustained. The remaining surface bruises and areas of deep bruising could have been caused during falls and collapse episodes, the various physical altercations or the restraint by police officers. Indeed, in the absence of specific injuries it was not possible to give any pathological indication as to the force applied to his back during the restraint or his struggling against the restraint.

[94] As mentioned above there were multiple injuries to the arms and legs, and the vast majority of these were non-specific with multiple possible causes. Of note, however, there were bruises, abrasions and lacerations on the back of the hands, particularly severe on the right hand. Whilst these may have been the result of his punching a hard surface, it is also possible that these injuries were caused during fall and collapse episodes. There was also heavy bruising, as well as abrasion and laceration, of the palmar surface of the hands which could be accounted for by falls onto an outstretched limb or other contact with a hard surface, such as forceful slapping. In addition, there were multiple superficial lacerations transversely across the distal part of the front of the left forearm, close to the wrist. Such wounds would be consistent with the forearm having come in contact with a semi-sharp object or objects, and in view of the repetitive parallel pattern one likely scenario was a section of the applied handcuffs. There were also horizontal bands of abrasion and bruising on the back of the left lower leg and inner aspect of the right lower leg, just above the ankles, and overlying the bony prominence on the inner side of the right ankle. Whilst it remained possible that these injuries were the result of the restraints and gripping applied by the police officers, it was difficult to be absolutely certain.

[95] The postmortem examination confirmed irreversible brain damage, a condition known as hypoxic ischaemic necrosis, which was consistent with having been caused as a result of insufficient oxygen being supplied to the brain, primarily during the cardiac arrest. Dr Lyness told the inquest such irreversible brain damage would be incompatible with life. Microscopic examination also revealed evidence to suggest that Mr McMahon had suffered rhabdomyolysis, which could account for the clinically diagnosed kidney failure. In addition, there was acute inflammation of the lungs, consistent with pneumonia, which is a common finding in an individual with a reduced level of consciousness, including those dying from irreversible brain damage.

[96] Dr Lyness told the inquest that in addition to the above, the autopsy revealed moderate degenerative narrowing of one of the coronary arteries of the heart. This pre-existing heart disease would have reduced the flow of blood to the heart muscle and, to a degree in the opinion of Dr Lyness, would have rendered Mr McMahon less able to withstand the extreme physiological strain placed on his body secondary to the physical restraint, ABD and cocaine toxicity.

[97] In summary, Dr Lyness opined that there is little doubt that Mr McMahon demonstrated some form of an ABD due to the toxic effects of cocaine. He was subsequently physically restrained by police officers and suffered a cardiac arrest. However, Dr Lyness considered it extremely difficult, from the autopsy findings alone, to state with absolute certainty as to what relative extent the physical restraint, ABD, cocaine toxicity, rib fractures, exposure to CS spray, obesity and coronary artery atheroma played in the complex interactions that precipitated the acute deterioration in his condition prior to his admission to hospital. He recorded the cause of death as:

1(a) Hypoxic ischaemic necrosis of brain, pneumonia and multiple organ failure

Following:

Cardiac Arrest during physical restraint

In association with
An acute behavioural disturbance, cocaine toxicity, Rib fractures, Exposure to CS Spray, Obesity and Coronary Artery Atheroma.

Other Expert Evidence

Dr Nathaniel Cary – Forensic Pathologist

[98] Solicitors acting on behalf of the next of kin instructed Dr Nathaniel Cary, an experienced Forensic Pathologist based in Oxfordshire, to produce a report for use at the inquest. Dr Cary gave oral evidence to the inquest using the remote Sightlink facility. Dr Cary indicated that he had considerable experience investigating restraint deaths.

[99] Dr Cary commented on the report and evidence of Dr Lyness. He told the inquest he was not convinced that the rib fractures contributed to the cardiac arrest. Instead he considered the fractures to have been caused by chest compressions during CPR. He did not think that CS Spray played an important role and he did not agree with the inclusion of coronary artery atheroma.

[100] On the issue of the coronary artery atheroma Dr Cary told the inquest that the 60% occlusion noted by Dr Lyness during the post-mortem examination fell below the level considered by most pathologists to be significant.

[101] Dr Cary told the inquest that, in his opinion, while it is difficult to precisely evaluate the role for each component in the cause of death, prone restraint was more than a minimal factor. He thought that at the time of the restraint Mr McMahon would be vulnerable because he would have still been suffering from the effects of a metabolic disturbance resulting from prolonged exertion. He should have been treated as a medical emergency and restraint should have been avoided. Dr Cary said it was important to consider that a cardiac arrest occurred during the course of a restraint. He accepted that the restraint was not a prolonged restraint and lasted for only a relatively short period of time. Nonetheless, Mr McMahon had been overpowered, compressed from behind and deprived of oxygen. These factors in conjunction with an ABD precipitated a cardiac arrest.

[102] Dr Cary told the inquest that he would put restraint at the top of contributory factors leading to death. He accepted that not every individual who consumes cocaine will suffer an ABD. Indeed, he said that despite the fact that cocaine is abused on a grand scale in the UK, there are relatively few deaths associated with cocaine abuse. Dr Cary also considered that the nature and length of the restraint would have been unlikely to have adversely affected a 'healthy' individual not under the influence of cocaine or suffering an ABD.

Dr Richard Shepherd – Forensic Pathologist

[103] I instructed Dr Richard Shepherd, a hugely experienced forensic pathologist with an international reputation, to comment on all aspects of the pathological findings. Dr Shepherd gave evidence in a multi-witness format (sometimes known as 'hot tubbing') along with Dr Cary and Dr Lyness.

[104] Dr Shepherd produced a detailed report which included a number of conclusions arranged in defined categories. He also provided a glossary of medical/pathological terms in the appendix to his report which I know all of the legal teams found extremely useful. I have reproduced his conclusions below for completeness:

> ***General***
>
> *Gerard McMahon was an obese young male who had admitted abusing cocaine for some months. Sexualised behaviour had been noted on occasions when he was likely to have taken cocaine.*
>
> *He left his house late on 7th September 2016 with a friend and went to a club in Belfast where it is most likely that he took some cocaine. His behaviour became sexualised. He was ejected from the club and restrained for approximately 3 minutes by security staff.*
>
> *The subsequent events are documented in statements and on CCTV images and included loss of clothing, bizarre behaviour, many falls and he may have been kicked on more than one occasion.*
>
> *The initial contact with Police was not violent but Mr McMahon fell backwards and then lay on his back on the road with his legs up in the air for a short time. He was handcuffed to the front and taken to sit in the steps of the Grand Opera House.*
>
> *He appeared calm for a short time but then became agitated and a struggle followed during which CS gas was discharged and he was placed face down on the footpath with two officers holding his upper body and one his legs.*
>
> *One officer placed his right knee on the upper back of Mr McMahon and appears to have remained in that position for 1 minute and 50 seconds.*
>
> *At that time the officers appear to realise that Mr McMahon was not responding and they turn him onto his back and after a delay started resuscitation. I note the comments made by Dr Meng Aw-Yong concerning this delay in commencing resuscitation.*

He was treated by paramedics at the scene and then by medical staff in hospital but his brain had been so badly damaged by lack of blood and oxygen during the cardio- respiratory arrest that recovery was not possible and he developed multiorgan failure and a terminal pneumonia.

Toxicological analysis confirmed that Mr McMahon had taken cocaine and alcohol.

Injuries

Mr McMahon had suffered many blunt force injuries to many areas of his body. Most can be accounted for by the documented falls. These injuries would have been expected to be painful and to have limited activity in an individual not under the influence of cocaine.

The injuries to the neck are most likely to have been caused by direct forceful pressure to the neck such as the application of a neck hold. This set of injuries, in particular the fractured laryngeal component, would have been painful in normal circumstances.

I agree with Dr Cary that the anterior rib fractures are most likely to be the result of resuscitation and therefore are not a contributory cause of the cardiac arrest.

The possibility that the 3rd – 8th right lateral rib fractures had been caused earlier in the evening by falls or as a result of kicks cannot be excluded but they could also have been caused during resuscitation.

If received before his collapse these six adjacent rib fractures would normally be expected to be painful and that pain would have restricted both general movement and in particular also breathing. Mr McMahon's activities do not appear restricted and he was not seen to be holding the right side of his chest at any time.

Rhabdomyolysis

The majority of the raised Creatinine Kinase (CK) recorded by Dr McCaroll must have resulted from damage to the skeletal muscle although damage to the heart muscle and the brain may also result in the release of small amounts of CK.

The presence of myoglobin from skeletal muscle in the kidneys confirms that there must have been damage to those muscles.

A component of this damage could have been due to direct blunt trauma but the very high level of CK cannot be explained by blunt trauma alone.

Damage to skeletal muscles (rhabdomyolysis) is known to be associated with cocaine use
CK is increased in the hours following a myocardial infarction (death of heart muscle) but not following a cardiac arrest from other causes. I note that only focal, very minimal, microscopic damage to the heart muscle was detected by Dr Lyness.

The very low eGFR and raised creatinine noted on first arrival at A & E indicates that severe kidney failure was established at that time. This renal failure may have resulted from the

deposition of myoglobin in the kidneys following skeletal muscle damage however the possibility that a component of the renal failure may have resulted from the secondary damage to the functioning of the kidneys caused by lack of blood during the cardiac arrest cannot be excluded.

Mr McMahon had a slightly raised potassium level on first arrival at ED any rhabdomyolysis would have contributed to this increase.

Acute Behavioural Disturbance

In my opinion the bizarre behaviour exhibited by Mr McMahon for approximately 3 hours from the time in the nightclub when he exposed his genitals to his restraint outside the Grand Opera House is entirely consistent with a diagnosis of Acute Behavioural Disturbance following ingestion of cocaine.

It is well documented that individuals in this state should be treated as a medical emergency from the outset as they are known to be at an increased risk of sudden collapse and death.

I am surprised that a call for medical assistance was not made at the point of initial contact by the officers especially if they had been made aware of his behaviour in the preceding hours or that such a call had not made even earlier by those actively viewing the CCTV on the night when Mr McMahon's behaviour would have been noted.

Restraint Research

A review of the medical evidence regarding experiments on restraint confirms that it has all been performed on fit and healthy volunteers and that some of this research has demonstrated statistically relevant but not clinically significant changes in the physiological parameters that were measured.

It is well established that sufficient restriction of the movement of the chest and / or abdomen can cause death and two scenarios are not infrequently encountered in forensic practice, those of traumatic and positional asphyxia, although the distinction between the two may lie more in the actions, events and forces applied rather than in the pathology.

Logically the effects of the restriction of movement of the chest /abdomen must lie on a spectrum with rapid death at one end and no significant effect at the other. It follows that, for any individual at any particular time, there will be a point on this spectrum marking the place where, if sufficient restriction occurs, it could have critical and possibly fatal cardio-respiratory effects.

However, there is no data at present to support the theory that the forces that are commonly applied during physical restraint of an individual by others, including the application of pressure to the chest / abdomen, causes sufficient adverse effects on the lungs and/or the heart in healthy adult subjects to cause the six measured physiological parameters to be displaced outside their normal clinical / physiological ranges and so be likely to cause death.

That Mr McMahon was obese and that he was not "fit and healthy" during that night is clear. His documented 3 hour progress through Belfast demonstrates how he has been psychologically affected, the hours of near constant activity would also have had both physical and metabolic

effects and these would have been combined with the physiological effect of ingesting cocaine.

The research that has been performed does not provide any useful indications about what may happen in such "real-life" circumstances but worldwide experience of many similar cases over the years, some of which have resulted in death, does indicate the potential risks of restraining individuals, and particularly obese individuals, in these circumstances.

This matter is more complicated as it is not an "all or nothing" situation. Some individuals suffering from cocaine induced ABD will die without being restrained, while others are restrained and yet suffer no overt adverse consequences.

The theoretical potential risks of restraint have been enumerated in numerous documents but at the time of restraint it is the status of that individual at that time (which cannot be known) and their individual response to restraint (which cannot be predicted) that will be crucial to the outcome.

Cause of Death

Because of the many confounding factors, many of which are unknown, it is extremely difficult to assess the relative contributions of each in the death of any individual while being restrained.

I concur with Dr Lyness and Dr Cary that the brain damage, multi-organ failure and pneumonia while correctly placed first in the Cause of Death, were all the consequence of the cardiac arrest and it is the cause of that cardiac arrest that is important.

As noted earlier I do not think that the rib fractures, however caused, would have played a significant role nor do I think that there is any evidence that the CS gas had a significant effect on Mr McMahon.

I concur with Dr Cary that the degree of coronary atheroma noted is highly unlikely to have played a significant role in normal circumstances.

Mr McMahon's obesity may have been significant in terms of the prone restraint but, in my opinion, it is most probably encompassed by the use of the term "restraint".

I would favour the following narrative phraseology:

Cardiac arrest during restraint of an individual suffering from cocaine induced Acute Behavioural Disturbance.

Dr Meng Aw-Yong – Emergency Medicine

[105] Dr Meng was instructed by PONI and his three reports were admitted pursuant to Rule 17 of the 1963 Rules. Rather than reproduce large sections from the reports of Dr Meng I have below outlined some of the more salient points from all three reports:

a) *Post-mortem findings exclude the possibility that Mr McMahon's behaviour was due to a brain injury or tumour. They also exclude any head injury having been caused by any members of the*

public. The findings confirm that Mr McMahon did not receive enough oxygen at some time, most likely before or during his cardiac arrest.

b) It is not possible to be certain as to the cause of the laryngeal fracture.

c) The rib fractures are consistent with chest compressions.

d) The multiplicity of minor injuries described by Dr Lyness are unlikely to have caused a cardiac arrest.

e) It is likely that use of cocaine and alcohol have precipitated the development of Acute Behavioural Disturbance.

f) Mr McMahon demonstrated an ABD, described by the Royal College of Emergency Medicine as, "the sudden onset of aggressive and violent behaviour and autonomic dysfunction, typically in the setting of acute on chronic drug abuse or serious mental illness. Its presentation is associated with sudden death in approximately 10% of cases."

g) Early recognition of ABD changes the situation to a medical emergency. In London there is an agreement with the Metropolitan Police Service ('MPS') and the London Ambulance Service that any suspected ABD cases trigger a response from an Advanced Paramedic Practitioner, who is able to sedate the patient. Extensive work has been undertaken within the MPS to educate officers regarding ABD.

h) There are no concerns with the management of Mr McMahon while he was being treated in the ED or ICU.

i) There are concerns about PSNI handover and management of the scene.

j) There are no concerns regarding the actions of the paramedic crew who followed the relevant guidance.

k) There is no research which links the use of pepper spray with onset of ABD. There is no reference to an increased state of agitation when Cs Spray is used on Mr McMahon.

l) The 60% atheromatous thickening of the heart blood vessel would increase the risk of a cardiac arrest. Cocaine may have exacerbated this by causing coronary vasospasm and by increasing heart oxygen demand.

m) Research points to a very poor survival outcome for Mr McMahon despite the quick response time of the Ambulance. The initial heart rhythm when the Ambulance crew attended was asystole. 2017 cardiac arrest outcome data from all English Ambulance Services show that 27.7% regained a heartbeat and were admitted to hospital. Only 8.1% survived to leave hospital. However, when the initial heart rhythm was noted to be asystole 15.3% had a return of circulation and 1.4% left hospital alive. Those presenting with asystole have a very poor prognosis – 10% survive to admission with only 0-2% surviving to discharge.

n) *There was a delay of approximately 3 minutes in commencing chest compressions but this is unlikely to have contributed significantly to survivability. Even if officers started chest compressions immediately it is unlikely that Mr McMahon would have survived.*

o) *On balance the short restraint by officers is unlikely to have contributed significantly to the severe acidaemia shown by Mr McMahon. The high potassium (K) level and acidosis is likely to have developed over the course of the early morning, from at least 2.00am. This would be exacerbated by the use of cocaine, obesity and atheroma. It cannot be certain if Mr McMahon would have gone into cardiac arrest without restraint.*

p) *The fact that circulation was restored is likely due to the CPR performed by police officers and treatment by paramedics.*

Mr John H Scurr – Consultant General and Vascular Surgeon

[106] Solicitors acting for Officers A, B and C instructed Mr Scurr. He produced a reported which was admitted pursuant to Rule 17 of the 1963 Rules. Dr Scurr examined the evidence at inquest and concluded as follows:

a) *This man suffered multiple superficial injuries. The most serious injuries, fractures to his ribs, almost certainly related to attempts at cardio-pulmonary resuscitation.*

b) *This man's heart stopped. Prior to being restrained by the police officers, this man was displaying extremely erratic behaviour, probably fuelled by a combination of alcohol and cocaine. The duration of his restraint by the police officers has been recorded on CCTV footage.*

c) *It would appear that he was restrained for a period of two minutes, followed by a further almost two minutes when his heart was noted to have stopped. At this point resuscitation was restarted and continued by an ambulance crew. I note he was successfully resuscitated and taken to hospital where his overall condition deteriorated until he died.*

d) *This was a relatively young man who was relatively fit. He did have evidence of arteriosclerosis with a 60% reduction in his anterior descending coronary artery.*

e) *There are a number of factors which will cause cardiac arrest. They include a primary cardiac cause, i.e. myocardial infarction with or without rhythm disturbances. A lack of oxygen. Although the heart is relatively sensitive, people can survive for up to ten minutes without oxygen. The brain is often more affected than the heart itself.*

f) *Other factors causing cardiac arrest include medication, which can cause rhythm disturbances such as ventricular fibrillation where although the heart is still functioning it is not functioning efficiently, with no cardiac output. Recreational drugs including cocaine are known to have an effect on the heart. Cocaine can be associated with rhythm disturbances and has been well-recognised in increasing difficulties with resuscitation.*

g) *The general distribution of bruising would be entirely consistent with multiple fights, punches and blows.*

h) *Obstructing the airway or preventing air from entering and leaving the lungs would produce a slow but progressive fall in arterial PO2. The arterial PO2 would take up to ten minutes to show a significant fall, or a fall significant to have an effect on cardiac function. Even in the absence of significant hypoxia, cocaine is known to have an effect on the myocardium*

i) *Patients undergoing surgical treatment for multiple injuries following the ingestion of cocaine have been seen to have major rhythm disturbances. These disturbances are sometimes difficult to control, even in the presence of a hospital setting.*

j) *In summary, this man is recorded as behaving in an abnormal manner which would be entirely consistent with excess alcohol and/or cocaine.*

k) *The injuries sustained by this man is consistent with multiple blows. He sustained a cardiac arrest shortly after being restrained by police officers and probably no more than four minutes after the restraint process began. Whilst the restraint could cause some difficulties with him breathing, a relatively short period of restraint is unlikely to have caused severe hypoxia consistent with cardiac arrest.*

l) *On the balance of probabilities the cardiac arrest was due to cardiac arrhythmias contributed to by cocaine and the evidence of arteriosclerosis.*

m) *The inability to fully resuscitate this man despite initial attempts at restoring his circulation, again would suggest an underlying medical problem.*

Dr Thomas Trinick – Consultant Chemical Pathologist and General Physician

[107] Solicitors acting on behalf of Officers A, B and C instructed Professor Thomas Trinick. He produced a report which was admitted pursuant to Rule 17 of the 1963 Rules. Professor Trinick included a useful section outlining some background information on cocaine, some of which I have reproduced below:

1. *Cocaine is a strong stimulant made from the leaves of the coca plant which comes originally from South America. There it is chewed or made into a tea for refreshment and to relieve fatigue. It was isolated in the 1880s and used as a local anesthetic in eye surgery. It was particularly useful in surgery of the nose and throat because of its ability to provide pain relief and constrict blood vessels, thereby limiting bleeding.*

2. *Cocaine was legal and was an ingredient of the original Coca-Cola. Sadly, cocaine has become a common and dangerous drug of abuse. It is the most common drug related emergency in A&E. A cocaine use disorder is a problematic pattern of using cocaine that causes impairment in everyday life or causes distress that is noticeable.*

3. *Cocaine is a central nervous stimulant or 'upper' with local anesthetic properties. Its effects in order of descending frequency are, euphoria, stimulation, reduced fatigue, loquacity, sexual stimulation, increased mental ability, alertness and increased sociability. High doses are associated with tremor and convulsions. Small doses slow the heart through a vagal mechanism*

and large doses increase heart rate and even more so when combined with alcohol. This is part of the mechanism that links heart attacks to cocaine.

4. *High doses of cocaine create delusions, suspicions and anxiety. As the drug effect wears off these may be followed by depression and a persecution complex. Cocaine is well-absorbed through the oral, nasal, gastrointestinal, rectal, and vaginal mucosa, or via the lungs following inhalation.*

5. *Specific testing is usually for benzoylecgonine (BE), the major urinary metabolite of cocaine, is the analyte usually tested for in blood, urine, saliva, hair, and meconium. Cocaine itself is rapidly metabolized, and detectable in blood and urine only briefly (i.e., several hours) after use. BE can be detected in the urine for several days following intermittent use and up to 10 days or more after heavy use.*

6. *Unintended adverse behavioural effects occur with increasing dose, duration of use, or a more efficient route of administration (e.g., intravenous or smoked versus intranasal). These effects include dysphoric mood (anxiety, irritability), panic attacks, suspiciousness, paranoia, grandiosity, impaired judgment, and psychotic symptoms such as delusions and hallucinations. Up to one-quarter of non-treatment-seeking cocaine users may experience anxiety, depression, sleep disturbance, or weight loss (due to appetite suppression and changes in fat regulation). Concurrent behavioural effects include restlessness, agitation, tremor, dyskinesia, and repetitive or stereotyped behaviours such as picking at the skin. Associated physiological effects include tachycardia, pupil dilation, sweating, and nausea, along with reflecting stimulation of the sympathetic nervous system. Cocaine-associated psychotic symptoms (paranoia, delusions, hallucinations) are common and reported by up to 80 percent of individuals with a cocaine use disorder. These symptoms resemble those due to acute schizophrenia.*

7. *A transesterification reaction between ethanol and cocaine produces a unique agent called benzoylmethylecgonine, also called cocaethylene. Cocaethylene has a long duration of action, up to 13 hours depending on the route of administration, like cocaine, cocaethylene is vasoconstrictive, cardiotoxic, dysrhythmogenic and neurotoxic. When mixed with alcohol the effects of cocaine last up to two and a half times longer. This metabolite remains in the body much longer, subjecting the heart and liver to a prolonged period of stress. That may be why some of the recorded deaths from Cocaethylene occur up to 12 hours after the user has mixed substances and the risk of sudden death is 18 times greater when alcohol and cocaine are used together. What is even worse is that you can't see it coming, you could be feeling completely fine one minute and dead the next.*

8. *Acute cocaine use is associated with arterial vasoconstriction and enhanced thrombus formation. It causes tachycardia, hypertension, increased myocardial oxygen demand, and increased vascular shearing forces. Cocaine causes coronary vasoconstriction in a dose-dependent fashion and is associated with cardiac ischemia in 5.7 percent of patients and arrhythmia in 4.8 percent of patients with cocaine-related visits to the emergency department.*

9. *Acute cocaine use is associated with a number of cardiovascular conditions, including:*

    i. *Myocardial ischemia or infarction.*
    ii. *Arrhythmias.*

10. *Cocaine may also enhance the release of adrenaline/noradrenaline from central and peripheral stores. What this means is that cocaine exposed Mr McMahon to the ongoing effects of adrenaline in a very major and dangerous way. An acute coronary syndrome (heart muscle ischaemia or heart attack) is the most common cardiac condition associated with cocaine use and can occur with all routes of cocaine ingestion. The most common acute condition is myocardial ischaemia, only 6 percent of patients with chest pain and recent cocaine use sustain a myocardial infarction (MI). An MI in this setting is not related to the dose or frequency of cocaine use, although approximately one-half of patients who present with cocaine-related MI have had previous episodes of chest pain. Most cocaine-associated MI's occur in the absence of high grade atherosclerotic coronary artery narrowing. There is no evidence that pre-existent cardiovascular disease or other abnormalities are prerequisites for the development of cocaine-related myocardial ischaemia.*

[108] Professor Trinick also included a similarly useful section on Acutely Disturbed Behaviour, some of which I have reproduced below:

> *"The term of 'Acutely Disturbed Behaviour' (ADB) has been adopted to cover the acute mental state associated with an underlying mental or physical disorder, symptoms of which range from agitation and distress (which may or may not lead to aggression or violence) to actual aggression or violence that causes harm or injury to another person or damage to property. The violence or aggression can be physical or verbal. I understand this terminology is used across the UK. Management of ADB is multifaceted and in addition to medication should incorporate de-escalation techniques and non-pharmacological measures. In January this year in Northern Ireland a Regional Guideline for the Management of Acutely Disturbed Behaviour was released for consultation to the Health Service in Northern Ireland. (Regional Guideline for the Management of ADB Consultation Process 2021). There are many medical reasons for ADB. Some are given below:*
>
> *i. Head injury*
> *ii. Cocaine abuse*
> *iii. Alcohol and sedative-hypnotic withdrawal syndromes*
> *iv. Heat-related illness*
> *v. Thyroid storm*
> *vi. Subarachnoid haemorrhage*
> *vii. Brain tumour/abscess*
> *viii. Infections of the central nervous system (i.e., meningitis and encephalitis)*
> *ix. Several psychiatric diseases.*
>
> *The majority of these diagnoses are determined from the patient's medical history. A review of the patient's medications and a detailed account of their substance abuse preferences through family, friends, and para-medics, may provide the answer. Diagnostic testing may include computed tomography (CT) scan of the head and lumbar puncture as*

appropriate."

[109] Professor Trinick concluded that Mr. McMahon suffered from 'cocaine use disorder,' and after taking cocaine and alcohol together on a number of previous occasions which were followed by bizarre behaviour, on the evening of 7 and 8 September 2016 he developed 'Acutely Disturbed Behaviour' probably with aggression and paranoia following the ingestion of cocaine and alcohol.

[110] The mixture of cocaine and alcohol resulted in the formation of cocaethylene in the liver. This substance was identified in blood samples from Mr. McMahon. Cocaethylene is vasoconstrictive, cardiotoxic, dysrhythmogenic, and neurotoxic. Cocaine-associated psychotic symptoms (paranoia, delusions, and hallucinations) are reported by up to 80 percent of individuals with a cocaine use disorder and unfortunately Mr. McMahon appeared to exhibit all of them.

[111] Professor Trinick considered that Mr McMahon was a very ill man leading up to the restraint as a result of toxicity. His degree of illness became more severe to the point where his condition threatened his survival. The fact that he was ill was apparent in his behaviour on CCTV, but the degree of his illness would not have been easily apparent to non-medically trained individuals.

[112] He concluded by saying, it is very likely that Mr McMahon experienced a fatal arrhythmia while he was being constrained on the ground, which very sadly resulted in his death.

Mr Eric Baskind - Consultant in violence reduction, the use of force, physical interventions, restraints, management of violence and martial arts systems

[113] Solicitors acting for the next of kin instructed Mr Eric Baskind to produce an expert report. Mr Baskind also gave oral evidence to the inquest using the Sightlink facility.

[114] Mr Baskind told the inquest that police officers receive initial and refresher training in the use of force and related matters in accordance with a manual of instruction and guidance. The high-level manual of instruction and guidance is now published by the National Police Chiefs' Council and the College of Policing and is known as the Personal Safety Manual ("the Manual"). The Manual exists for the guidance of chief officers in carrying out their duties to provide appropriate training and policies, and for police officers and police staff who may be required to deal with conflict as part of their role. The Manual should be used in conjunction with the Guidance on Personal Safety Training published in 2009 on behalf of the (then) Association of Chief Police Officers. The Manual is intended to be a reference point for officer safety tactics and procedures for all relevant personnel. The Manual provides

general guidance on use of force issues and includes a directory of techniques, all of which have been the subject of medical and legal review.

[115] Although it is not intended that officers or staff should be trained in all of the techniques set out in the Manual, individual forces are required to ensure that only techniques contained in the Manual are taught to force personnel. This means that individual forces will be able to select techniques from the Manual that may be required for specific policing problems or specialist roles under the umbrella of the police national Personal Safety Training Programme. This approach enables flexibility whilst, at the same time, recognises that the understanding of the techniques and the standard by which competence is measured should be uniform.

[116] Mr Baskind told the inquest that refresher training should be repeated periodically where appropriate. He said periodic training is usually provided annually or more frequently should it be needed. It is important for officers to undergo regular physical skills refresher training as a failure to refresh such skills is likely to lead to a degradation of skill retention and recall and will increase the margin of error and the risk of foreseeable injury. It is unrealistic to expect officers to use these skills competently and safely if they do not undertake regular refresher training and it would be wrong to suggest that an officer would maintain a suitably sufficient degree of competence without the ability to have their skills refreshed, monitored and reviewed on a regular basis.

[117] Regarding periodic training Mr Baskind explained that the Manual explains that forces should ensure that adequate training and periodic refresher training is provided. Where an officer is not currently trained, or where they have not attended all aspects of training or refresher training, Mr Baskind said consideration should be given to whether they should be allowed to perform operational duties and continue to possess items of work equipment individually issued to them.

[118] Mr Baskind provided his opinion on the e-mail from Assistant Chief Constable Martin dated 24 April 2014 regarding PSP training which said:

> *"Colleagues this email is sent out as a reminder. Most officers are trained in Personal Safety Techniques. Once trained accreditation does not lapse. Nevertheless, annual refresher training should be undertaken and will be of benefit to you. Individual officers and their line managers should ensure that refresher training opportunities are availed of. To be clear, not attending refresher training does not exclude you from operational duty."*

[119] Mr Baskind opined, this email appears to contravene the requirements for regular refresher training set out above and the principles of best practice.

[120] Mr Baskind was able to view the entirety of the restraint using CCTV footage. In relation to initial contact between police officers and Mr McMahon when handcuffs were applied Mr Baskind said that although officers are trained generally to apply handcuffs to the rear, there are circumstances where they can be applied to the front. Handcuffing to the rear is more secure and restrictive than handcuffing to the front. He said he would not criticise the officers for handcuffing Mr McMahon to the front and, having done so, it would probably not have been sensible to remove them to reapply to the rear as this would have presented Mr McMahon with an opportunity to resist or attack the officers which would then have required further restraint with additional risk of harm.

[121] Mr Baskind also considered the potential for use of CS Spray at this stage and thought that although there would have been no justification for Mr McMahon to have been sprayed with irritant spray, the aiming of the canister with a verbal warning can often help diffuse a situation.

[122] Mr Baskind considered the bizarre behaviour exhibited by Mr McMahon to be typical of a person with ABD. This behaviour, he continued, included Mr McMahon hurling a metal sign towards a taxicab; becoming involved in an altercation with security staff at Thompson's nightclub; removing his clothes apart from his boxer shorts and running around in bare feet including into the roads; walking around with his trousers at his ankles without remedying the same despite this causing him continually to fall over; standing, sitting and lying in the middle of roads; waving his arms oddly and making odd noises/shouting; becoming involved in an altercation with taxi drivers; smashing the windscreen of a van; splashing around and attempting to drink from a puddle in the road; and falling backwards onto the ground possibly in an exaggerated manner.

[123] Mr Baskind told the inquest that information about the above incidents was extremely important to the officers attending Mr McMahon and ought to have informed the way in which they approached and dealt with him. He thought that information about Mr McMahon's behaviour which suggested he was suffering from ABD should have been communicated to the officers dealing with him. Additionally, the attending officers ought to have identified for themselves that there was a strong possibility that Mr McMahon's bizarre behaviour was the result of ABD.

[124] Mr Baskind accepted that in many cases, it is difficult to distinguish between a person displaying the signs of ABD from a person behaving with extreme violence without such an underlying medical condition. However, in this case, a review of the CCTV footage showing Mr McMahon's behaviour when interacting with the officers, clearly showed the former rather than the latter.

[125] In relation to the training provided to PSNI officers Mr Baskind was of the opinion that the training provided to police officers covered ABD. In arriving at this conclusion he considered two versions of the PSNI training manual: one marked 2011 ("the 2011 Manual") and the other 2017 ("the 2017 Manual"). He also considered Appendix E, PSNI Manual of Policy, Procedure and Guidance on Conflict Management ("Appendix E") which deals with Excited Delirium ("ED"). I have rehearsed his opinion on this issue below:

> *"Module 4 of the 2011 Manual "Medical Implications" provides the following guidance (page 5):*
>
> *Why is a subject in an acute behavioural disorder state of particular concern?*
>
> *Subjects suffering from acute behavioural disorder can die suddenly during, or shortly after, a strenuous struggle – whilst at hospital or in custody. Under "SAFETY POINT" it is noted that: Death can occur: BEFORE a struggle DURING a struggle or DURING restraint AFTER a struggle Death is most likely to occur in two ways:*
>
> 1. *The state of acute behavioural disorder causes the subject to have a cardiac arrest*
>
> 2. *The physical exertion leading to oxygen deprivation due to the activities prior to and possibly during restraint make an individual become more at risk from positional asphyxia.*
>
> *Page 6 of the manual: How do you control a subject experiencing ABD? This will always be very difficult. Officers will probably have to place the subject face down on the ground in order to handcuff them safely. The risk of positional asphyxia affecting a subject who is in a brain agitated state is far greater than for a normal violent subject. They may continue to struggle beyond their point of exhaustion and it will be very difficult to prevent this regardless of whether or not they are handcuffed. Actions to reduce the risk of death to a restrained subject exhibiting acute behavioural disorder:*
>
> - *Get the subject onto their side, into a kneeling or seated position as soon as possible*
> - *Never transport in a prone position if at all possible*

- *Pay close attention to the life signs of the subject and monitor closely, especially if the subject should suddenly become very passive.*

SAFETY POINT Any subject exhibiting symptoms of acute behavioural disorder should be treated as a Medical Emergency and should be medically examined immediately at a hospital regardless of any subsequent behaviour or apparent recovery. Examination at a police station may not be appropriate."

[126] Mr Baskind continued by telling the inquest that, although the 2011 Manual provides some useful guidance on ABD, it omits one of the most important pieces of safety advice: that is, wherever possible, officers should contain rather than restrain the subject and treat him as a medical emergency. He said containing a person includes containment within a room or part of a building as well as an area outdoors. Further, he opined that the guidance contained in the 2011 Manual that "Officers will probably have to place the subject face down on the ground in order to handcuff them safely" is incorrect and dangerous.

[127] It was Mr Baskind's view that although Section E5 of Appendix E provides guidance in similar terms to the 2011 Manual and advises officers to treat ED as a medical emergency it fails to advise officers to contain rather than restrain the subject wherever possible. He said although this defect was cured by the 2017 Manual, that manual post-dates the incident. However, he noted there also existed a 2015 manual which, in addition to the information noted above, sets out that "Officers should consider containment first, where practicable, before any physical intervention".

[128] When he considered the second part of the restraint, outside the Grand Opera House, Mr Baskind thought the use of CS Spray was neither proportionate nor necessary. Mr McMahon was already restrained with handcuffs and was not acting in any way that three officers, trained in restraint, should not have been able to manage safely without the use of the spray. In any event, police officers are taught that irritant spray should not be used on a person who is under restraint, including by handcuffs, unless the nature of the risk to the officer(s) is such that this cannot be avoided. Furthermore, it does not appear that the spray had any real effect on Mr McMahon.

[129] Mr Baskind told the inquest when Mr McMahon was attempting to rise from the step outside the Grand Opera House, as he was already seated, it ought to have been relatively straightforward, and certainly safer, to keep him in that position. He said if the officers allowed Mr McMahon to get to his feet, additional restraint options would likely have been needed which would have considerably increased the risk to Mr McMahon. However, restraining a person in the seated position is taught in many physical intervention systems, including that taught to police during personal safety

training. A seated restraint was an obvious tactical option and should have been used by the officers in place of the high-risk ground restraint when Mr McMahon became agitated and demonstrated his intention to move from the steps. The seated restraint suggested by Mr Baskind would have involved two officers sitting either side of Mr McMahon and applying a secure hold to his arms on their respective sides.

[130] Commenting on the restraint which took place on the ground Mr Baskind opined that the officers' attempts at restraining Mr McMahon were very poor with body weight and numbers being used rather than skill.

[131] Commenting specifically on ground restraint Mr Baskind accepted that, while no restraint can be free of risk, there are additional known risks associated with restraining a person on the ground. These additional risks fall into two main categories. First, the risk of injury to all parties during the descent to the ground and, second, the risk to the subject whilst held on the ground especially where his breathing is compromised and/or he struggles against the restraint. Consequently, ground restraints should be used extremely sparingly and never as the default option. When restraining a person on the ground it is important not to place weight on their body in such a way that their ability to breathe is compromised. This means that no pressure should be placed on the subject's chest, back or neck, and care must be taken to ensure that the restraint position does not restrict ribcage movement and uplift the abdominal organs, for example, by leaning into the subject in a way that may limit lung expansion. This is particularly important because the subject's agitation, exertion and struggle against restraint will increase his demand for oxygen, and risk factors such as obesity, intoxication and respiratory disorders may reduce his respiratory effectiveness. These are additional factors that the officers ought to have considered before taking Mr McMahon to the ground and restraining him there.

[132] In relation to monitoring of the detainee Mr Baskind told the inquest it is also important that the subject is effectively monitored during the restraint to ensure he can breathe, communicate and is not in distress. He said he could not see any evidence from the CCTV footage of the officers monitoring Mr McMahon while he was being restrained on the ground although, he conceded, this may have occurred but was not captured on the footage.

[133] Mr Baskind in his report and in oral evidence to the inquest arrived at a number of conclusions:

a) *There is little evidence of the officers attempting to communicate with Mr McMahon with the main aim of avoiding the use of restraint.*

b) *Mr McMahon was displaying the signs of ABD which should have been identified by the police officers involved.*

c) *Staff operating the CCTV cameras should be trained in identifying ABD so as to alert the appropriate medical staff in good time and provide this information to attending police officers.*

d) *Given the presentation of ABD, the officers ought to have given priority to containing rather than restraining Mr McMahon and treated him as a medical emergency.*

e) *There was an ideal opportunity for the officers to have held Mr McMahon in the seated position on the steps near the Grand Opera House.*

f) *The officers should not have taken Mr McMahon to the ground.*

g) *There is no evidence from the CCTV footage of the officers monitoring Mr McMahon whilst he was being restrained on the ground to ensure he could breathe, communicate and was not in distress.*

Police Policy and Procedure.

Chief Inspector John Keers

[134] Chief Inspector John Keers, presently attached to the PSNI College at Garnerville, provided a statement and gave oral evidence to the inquest. C/Inspector Keers has responsibility for the management of the Tactical Training Department. He told the inquest he has a total of 14 years' experience in a variety of training and training management roles in the PSNI.

[135] C/Inspector Keers told the inquest that in his experience, the PSNI policy and training with regards to PA and ED and/or ABD has been based on national policy. He explained that up until around 2018 the PSNI used the term Excited Delirium but now uses the term Acute Behavioural Disturbance.

PSNI Service Procedure 59/07

[136] C/Inspector Keers commented on PSNI Service Procedure 59/07, entitled "*Preventing Sudden Deaths Proximate to Police Restraint (service procedure for positional asphyxia /excited delirium)*". This Service Procedure, he explained, was first issued on 16 August 2007 and subsequently amended and reissued on 5 March 2009 and 18 May 2011. The Service Procedure 59/07 was distributed to Officers via publication on Police-Net (which is the PSNI intranet) and issued by e-mail to the whole of the police service.

[137] C/Inspector Keers told the inquest that this Service Procedure identifies that the PSNI has, for some time, recognised the causes, symptoms and risks arising from both PA and ED/ABD. This document set out the PSNI's advice to officers in relation to how they should act when using restraint to prevent sudden deaths arising from PA and ED/ABD. This document (which consists of 2 pages) was referred to during the inquest and I have considered the entirety of it.

PSNI Manual of Policy.

[138] The second document that C/Inspector Keers commented on was the PSNI Manual of Policy, Procedure and Guidance on Conflict Management ("the Manual"). The purpose of the Manual, he explained, is to facilitate understanding and to provide practical guidance concerning the use of force by police officers. The Manual incorporated PSNI policies and Service Procedures in relation to the use of force, including Service Procedure 59/07, into what was a consolidated and more comprehensive document. Service Procedure 59/07 represented the PSNI's guidance on PA and ED/ABD before the Manual was introduced.

[139] C/Inspector Keers explained that the Manual represents PSNI policy in relation to the use of force at the time of Mr McMahon's interaction with PSNI officers on 8 September 2016. In line with the evidence given by Mr Baskind, CI Keers told the inquest the Manual follows the policy, procedure and guidelines circulated to forces across the United Kingdom by the National Police Chief's Council ("NPCC"). The NPCC Personal Safety Manual provides the basis from which the PSNI and other police services draw their own guidance documents, but it is not itself a national training programme, rather, the NPCC provides a central resource for policy documents produced by police forces.

[140] The PSNI Manual was introduced in April 2013 and chapters were amended at various times and not necessarily at the same time as others. The version from February 2015 was in force at the time of Mr McMahon's death. The Manual is available to all officers on Police-Net (and is available online for the wider public). Areas of development and or policy change will be communicated to officers during training refresher events.

[141] C/Inspector Keers told the inquest that Appendix E of the PSNI Manual draws specific attention to the conditions referred to as PA and ED. The policy states that there is a risk of PA when restraining a person. In simple terms, officers are informed by the Manual that a subject can stop breathing because of the position in which they have been held. The policy ensures that officers know that PA is likely to occur when a subject is placed in a position that interferes with their breathing, particularly when they cannot escape from that position. ED is described as a condition where a person exhibits violent behaviour in a bizarre and manic way rather than just being simply violent. Appendix E states that both conditions should be treated as medical emergencies.

[142] In relation to the signs and symptoms of ED, paragraph E14 states:

"It should be noted that many of the signs indicating Excited Delirium are common to anyone behaving violently."

Paragraph E17 of Appendix E states that there is risk of death as a result of either a cardiac arrest for a suspect who experiences ED, and also notes that their efforts to avoid being restrained by police could put the person at greater risk from PA.

[143] The Manual at paragraph E18 advises that it is important to recognise the difference between ED and a violent outburst. The Manual recognises that even when ED is suspected, this does not mean that the use of restraint in the prone position will not be appropriate (see paragraph E19 of Appendix E) although it is noted that this may be more hazardous. Appendix E notes that a person suffering from ED may continue to struggle beyond their point of exhaustion, even if they are not restrained by handcuffs. Appendix E also notes that a subject may continue to be extremely violent in spite of the use of CS spray, handcuffs or batons. In such an event a person may continue to represent a continued risk of harm to him or herself, police officers and members of the public. Appendix E concludes with a mnemonic of 'A Medical Crisis' for police officers to use as an aide-memoire.

CS Spray

[144] C/Inspector Keers went on to explain that Chapter Four of the PSNI Manual covers the procedures and guidance for the deployment and use of CS spray by police officers. Officers are instructed by that policy that there are dangers associated with the use of CS spray inter alia in connection with the conditions of PA and EA and are advised to make themselves familiar with Appendix E of the Manual, discussed above. Paragraph 4.7 states that CS spray may be appropriate in circumstances whereby police are dealing with violence and where other levels of force are inappropriate and that the CS spray should be used as part of a graduated response. These conditions are identified as risks during arrest and restraint and the procedures which must be considered following the use of CS spray are explained.

[145] Additionally, officers are taught that CS spray should not be used on a subject who is restrained or handcuffed unless the nature of the risk to the officer is such that this cannot be avoided. Officers are also taught that there are risks associated with using CS spray on those who are vulnerable, whether through age or mental illness or as a result of having taken alcohol or drugs. Additionally, officers are advised that CS spray may not be effective in certain circumstances, and in fact might even exacerbate a violent situation. To that end, officers are advised that they should ensure that the control methods used, and the position that subjects are left in, does not adversely affect their breathing. They are also taught that subjects must not be left in a prone position.

PSP Refresher Training

[146] C/Inspector Keers told the inquest that training courses for several modules, including PSP training (which deals with restraint), should be attended and refreshed on an annual basis. The substance and content of some courses permit longer periods between refresher training. The decision that PSP training should be refreshed annually is a recognition that PSP is of particular importance for the protection of officers and the public. PSP refresher training will address the use of force by police officers and there is a need to ensure that officers are trained on the use of their fine and gross motor skills (such as the assessment of a threat, the assessment of a subject or the use of blocks and strikes). The PSNI has recognised that for a variety of reasons, including operational demand/pressures, logistics, temporary closure of training facilities for repairs etc, officers will not always be able to attend refresher training when notified. The Local Training Co-Ordinator ("LTC")/Operational ("Ops") Planning function is in place to recognise training needs and attempt to manage the allocation of training places as effectively as possible.

[147] An email from ACC Martin to the Service on 24 April 2014 highlighted that "once trained [in PSP], accreditation does not lapse." This email, said C/Inspector Keers, was to ensure that, while training opportunities should be availed of, officers who had not been able to undergo refresher training would still carry out operational duties.

[148] At the time leading up to Mr McMahon's death, PSNI officers received emails entitled "Reminder: Training Course(s) due to expire" to remind them that their training was due to expire and they were directed to contact their LTC in Ops Planning to secure a place on a training course. E-mails were sent weekly for a period of six weeks. It was the responsibility of the LTC or Ops Planning officer to arrange a date and time commensurate with the officers' duties and ongoing operational requirements. The personal responsibility upon an officer is further outlined within the PSNI's Code of Ethics (at page 18) wherein it states, in relation to Article 1 "Professional Duty":

> *"…you have a duty to keep yourself up to date on the basis of the information provided. It is recognized that the ability of police officers to perform their duties may depend on the provision of appropriate training, equipment and management support."*

[149] At the time leading up to September 2016, if an officer missed a refresher training and did not then seek to contact LTC/Ops Planning, there was no automated system reminder to prompt the arrangement of further training. However, all LTCs and Ops Planning officers would have been expected to monitor and manage the training requirements of their officers on an ongoing basis.

[150] In order to contextualise the PSNI's approach to refresher training in PSP, in particular, C/Inspector Keers contrasted it with the approach to firearms training. The PSNI's approach to supervising refresher training in firearms is (and was) different to its approach to PSP training, in recognition of the importance that the officer's training in the use of a firearm (that could be retained for personal protection) was kept current. Therefore, if an officer missed mandatory firearms training, their case would come before a specially appointed panel to examine the circumstances as to why this had occurred, and whether, pending further training being given, that person was competent to continue to hold a firearm.

[151] The difference in the PSNI's management of PSP refresher training and firearms training is reflective of the demands upon the organisation and what are considered to be the potential risks associated with an officer remaining operational, despite the fact that they had not attended a PSP refresher training event. Ultimately, it was considered that the risk for an officer to remain operational without necessarily having attended PSP refresher training was manageable, notwithstanding the fact that PSNI required and provided mandatory training. This was in contrast to the approach to an officer's continued entitlement to hold a personal protection weapon, when his training had lapsed.

[152] C/Inspector Keers acknowledged that by the end of 2015 PSNI recognised that its system of managing refresher training in courses like PSP required improvement. He said this led to the first of a series of audits of PSNI's systems at the start of 2016 and resulted in a series of practical steps being taken by the organisation to improve the systems whereby officers obtained and maintained the necessary training.

Training of Officer A

[153] Records revealed that Officer A had completed his first aid skills training course in July 2014. Training for first aid skills is expected to be renewed every three years, so it may be considered that this officer was up to date with this aspect of his training. The content of that First Aid course is directly relevant to issues of PA and otherwise dealing with medical implications of police actions. Officer A had completed his training at PSNI Garnerville on or around July 2011. He attended a PSP refresher in April 2012 and again in February 2013. Officer A was not defibrillator trained.

Training of Officer B

[154] Officer B also had a valid first aid training course and had completed a defibrillator course in July 2015, although the defibrillator training required updating annually. Officer B had graduated from PSNI Garnerville in and around November 2006 and he had completed a limb restraints course in February 2010; and had attended

a number of PSP refresher courses (May 2007, March 2009, February 2010, October 2011) the most recent of which was in November 2013.

Training of Officer C

[155] Officer C completed training at Garnerville around October 2014 and received a PSP refresher course around August 2015. He completed his first aid training in May 2015. Officer C had received defibrillator training in May 2015. The First Aid lesson plan includes information relating to PA.

[156] In relation to the PSP training received by Officers A, B and C, they had not attended annual PSP refresher training to varying extents as of September 2016. Officers A and B had not received PSP refresher training since early 2013. Officer C had received his last PSP training refresher in August 2015. Despite this, C/Inspector Keers told the inquest it is important to note in each case that these were officers who had been trained in PSP and that they had attended a variety of PSP refresher training courses since their initial foundation course. He said that the PSNI did not deem any of these officers' competence in PSP to be lacking at the time of their interaction with Mr McMahon, in accordance with the direction set out by ACC Martin.

Constable Hodgins

[157] Constable Hodgins, a police officer attached to Combined Operational Training based at Steeple PSNI gave oral evidence to the inquest. He is presently concerned with the development and delivery of the Public Order and Personal Safety Programme ("PSP"), including refresher training.

[158] Constable Hodgins was asked about the delivery of training prior to 2016 particularly in relation to ED/PA. He referred to an example course timetable which, he said, demonstrates that the course expressly dealt with restraint by officers and with the identification of PA and ED/ABD. He said that during each class a specific focus was placed upon awareness of observations of the person being restrained. By way of demonstration, a trainer would encourage trainees to actively reflect on the following questions, such as: "are they breathing?"; "are they talking?" if so, "what are they saying?" Constable Hodgins told the inquest that identification of PA and ED was (and still is) indirectly tested during practical exercises and prior to 2016 was not specifically taught as an isolated issue. Trainees were (and continue to be) referred again to the Manual where specific guidance is provided in respect of these conditions.

[159] Constable Hodgins, prior to providing his written statement to the inquest, was able to view the entirety of the CCTV relating to the interaction between Mr McMahon and Officers A, B and C. He provided some comments to the inquest:

(a) As Mr McMahon was being escorted to the Grand Opera House steps, the officers placed their hands on his upper body to support and guide him in that direction. Constable Hodgins considered this an appropriate and limited restraint.
(b) Constable Hodgins thought it was good practice when Mr McMahon was brought to the steps at the Grand Opera House and officers helped him into a seated position while they remained standing. He said this ensured the officers had the advantage of height, in the event that further restraint was required and represented an action in accordance with training.
(c) When the officers appeared to recognise the presence of injuries upon Mr McMahon's legs and used a torch to view these, Constable Hodgins thought this showed that the officers were performing an assessment of the need for medical treatment.
(d) Constable Hodgins said that it appeared that the officers were keen to restrain Mr McMahon in the seated position.
(e) Commenting on the restraint Constable Hodgins said, in his opinion, the method of restraint was not inconsistent with the training.

Conclusions

Thompsons Garage

[160] The first matter to be addressed concerns the interaction between Mr McMahon and members of security staff at Thompsons Garage nightclub. I am satisfied that Mr McMahon took cocaine while he was present within Thompsons Garage. I am also satisfied that he behaved in a way which concerned other patrons to the extent that they contacted security staff. This involved Mr McMahon having his trousers undone.

[161] The members of staff who removed Mr McMahon did so using reasonable force. Once Mr McMahon was outside the nightclub the security staff only reacted once Mr McMahon attempted to throw a punch. I am satisfied that he was verbally abusive to the security staff. He also can be seen with one of his hands placed down the front of his trousers. When McMahon attempted to strike one of the security staff at least four members of security staff intervened and took Mr McMahon to the ground. CCTV footage is not entirely clear as to what exactly occurred once Mr McMahon was taken to the ground by the security staff. One can be seen to place a hand around the front of his neck. The post-mortem examination found a fracture of the larynx which, in the opinion of Dr Lyness, could be consistent with a grab to the throat. However, all the pathologists considered that such an injury would have been painful. It is not apparent throughout the CCTV footage if Mr McMahon is feeling pain in that area. It is also apparent that Mr McMahon suffered a number of heavy falls onto hard surfaces during the course of his journey from Thompson Garage to Great Victoria Street. The fracture to his larynx could have occurred during one of these falls. Accordingly, I cannot be

satisfied as to how the fractured larynx came about, other than to say that I am absolutely satisfied, based upon the evidence of all three pathologists, that police officers did not cause this injury.

[162] I am satisfied that Mr McMahon's behaviour in Thompsons Garage was due to cocaine toxicity and most likely represents the genesis of an Acute Behavioural Disturbance (ABD). I am satisfied, having examined GP note and records, that this was not the first time Mr McMahon had experienced such a reaction after having taken cocaine.

Upper Arthur Street

[163] In relation to the incident which occurred in Upper Arthur Street, I cannot be sure what, if any, injuries were caused during the interaction between Mr McMahon and passers-by.

City Hall and Markets

[164] Once Mr McMahon reached the back of the City Hall he suffered a number of heavy falls. Members of the public can be seen to try and assist him but their efforts appear to be in vain. Mr McMahon's trousers are removed at around this point as well as his T-shirt and possibly one shoe. I am satisfied that this behaviour occurred as a result of an ongoing ABD. I cannot be sure what injuries, if any, were caused when Mr McMahon became involved with a member of the public in Friendly Way.

PSNI Calls

[165] The PSNI received an initial call regarding Mr McMahon at 2.47am. Further calls were received at 2.53am and 2.56am. A taxi driver also reported Mr McMahon directly to Grosvenor Road PSNI station. It is not clear at what time this report was made. The calls to police were categorised as 'priority' and a police crew was tasked to attend at the City Hall at 3.36am. I am satisfied, based upon the information available which did not include access to CCTV footage, that the category for these calls was correct. Although Mr McMahon's behaviour was odd there was no emergency and no immediately life threatening situation, notwithstanding the fact that Mr McMahon did, at this time, pose a risk to himself and other road users. The decision of the call handlers' not to seek assistance from the CCTV control room was not satisfactory. City Centre CCTV was available which covered the back of the City Hall and the call handlers should have sought to utilise this resource to glean further information about the male. Of course, utilising the CCTV is one thing, being able to appreciate that this behaviour may be as a result of ED/ABD is another. When they were interviewed both call handlers failed to appreciate the assistance they could have provided to their colleagues on the street. Training in recognition of ABD/ED along with access to CCTV

may have assisted with categorising the call and may also have assisted those officers who came to deal with Mr McMahon later. It is worth noting that the new PSNI ABD e-learning package, which I will discuss later includes an example (real life) scenario showing how an air support crew were able to advise colleagues on the ground about an individual showing signs of ABD.

Great Victoria Street

[166] The taxi drivers who confronted Mr McMahon when he was attempting to cause further damage to taxis in Great Victoria Street did not use excessive force when confronted by Mr McMahon. The decision to call police and to follow Mr McMahon to ascertain his location pending the arrival of police was sensible.

[167] The decision, made by Sergeant Tudge, to send two crews to Great Victoria Street was, similarly, sensible and proportionate.

Police interaction and restraint

[168] The initial interaction between Mr McMahon and Officers A and C was reasonable in all the circumstances. It was not unreasonable for Officer A to display his CS Spray pending compliance by Mr McMahon. It was also not unreasonable for Officer C to apply handcuffs to Mr McMahon to the front once he fell to the ground. I accept the evidence of Officers A and C that even though Mr McMahon was not showing any particular signs of being aggressive, there remained a risk given what had been reported regarding criminal damage to a vehicle window, that he may become aggressive. However, once the handcuffs were applied to the front, it seems to me a conversation should have taken place between Officers C and A concerning any potential risk and the appropriateness of the handcuffs remaining in the frontal position, as opposed to the rear. There were other opportunities to remove the handcuffs and place them to the rear, including when Mr McMahon was sat up from the ground. I do not accept the evidence from the officers that Mr McMahon would have to be placed face down for one handcuff to be removed and the position changed. Officers A and C had been appropriately trained in handcuffing techniques and would have been able to re-position the handcuffs.

[169] Constable Hodgins made it clear that handcuffing to the rear is to be preferred since it gives the officer more tactical options should a detained person become more aggressive. Officer B, the most senior of the officers at the scene, told the inquest that he had reservations about the handcuffs being applied to the front since it would have been his practice to always apply to the rear. Notwithstanding that, he did not communicate his concerns to either Officer A or C. Such a lack of communication when dealing with a detained person is clearly not helpful. As a result no conversation took placed regarding an assessment of any future risk.

[170] I have no issue with Constable Walker being sent to Lisburn Road PSNI Station to retrieve a cell van other than the obvious point that an ambulance should have been called in line with the guidance on ABD. As I will discuss later, the Officers did not suspect that Mr McMahon was medical emergency and therefore, the cell van would have been an appropriate way to transport Mr McMahon in his condition.

[171] I have had sight of the PSNI training material which covers the PSP refreshers completed by Officer A in February 2013, Officer B in November 2013 and Officer C in August 2015. The relevant guidance in place in 2013 was Service Procedure 59/07. In August 2015 the service procedure had been replaced by Appendix E.

[172] Service Procedure 59/07 is titled "*Preventing Sudden Deaths Proximate to Police Restraint*". At the outset it is noted:

> *"A number of incidents have resulted in the deaths of persons in custody in the UK (at least 37 between 2000 and 2005) due to conditions known as positional asphyxia and/or Acute Behaviour Disorder (Excited Delirium)."*

[173] The Service Procedure document goes on to provide guidance on Positional Asphyxia including causes, those persons who may be more at risk, signs and symptoms and what to do.

[174] There is similar guidance for "Acute Behavioural Disorder (or Excited Delirium)". Under the heading "Signs and Symptoms" the following are listed:

1. *Extraordinary Physical Strength.*
2. *Violence/Aggression*
3. *Full/partial dress*
4. *Shouting*
5. *Sweating fever, heat intolerance*
6. *Apparent ineffectiveness of CS Spray*
7. *Diminished sense of pain*
8. *Hallucinations*
9. *Acute onset paranoia*
10. *Disorientation*
11. *Panic*
12. *Impaired thinking*
13. *Attempts to break glass*
14. *Peron makes towards traffic.*

[175] Under the heading "What to do" it is indicated:

- ✓ *"If you suspect someone is suffering from an Acute Behavioural*

Disorder, treat as a medical emergency.

- ✓ *Contain rather than restrain where possible.*

…

- ✓ *The prone position should be avoided if possible. If the prone position is necessary, be mindful of the risks of positional asphyxia and do not keep the person in this position.*

…

- ✓ *Continue to monitor the person carefully."*

[176] The next heading "Treat both these types of cases as a Medical Emergency" provides the following advice:

- ✓ *"Once you restrain a person and they are handcuffed, do not hold them face down. Get them on to their side or into a sitting, kneeling or standing position as soon as it is safe to do so. The person may continue to kick at you, however, you must get them off their stomach as soon as you can.*

- ✓ *Call for an ambulance and communicate the situation clearly to medical staff.*

- ✓ *If the restrained person suddenly becomes quiet and stops resistance, monitor their vital signs carefully. If awaiting the arrival of medical assistance prepare for the possible use of CPR."*

[177] I was told at inquest by a number of the pathologists that ABD is a rare event. Although there is an increasing awareness among law enforcement officers about the risks of ABD, in 2016 this was a condition of which there would not have been such awareness and understanding as in 2021. Nonetheless the PSNI had developed a policy relating to ABD/ED and PA which outlined the signs, symptoms and risks. It was accepted at inquest that both documents (59/07 and Appendix E) accurately set out details regarding ABD/ED and PA. On this basis I am satisfied that the PSNI had suitable awareness and information available with which to train its officers.

[178] Constable Hodgins told me that in 2013 (when Officers A and B completed their PSP refresher) and 2015 (when Officer C completed his PSP refresher) the guidance documents were not made available in written format to officers during PSP refresher training. He told the inquest that guidance on ABD/ED and PA would have been provided during sessions on restraint, handcuffing and first aid. Constable Hodgins told me that both documents were available on the PSNI Intranet (PoliceNet) and on that basis would have been available for each officer to read if they wanted to. Issues regarding ABD/ED and PA were not presented during training in a classroom format, for example, using a white/black board. I was able to see a class plan for each PSP module. Although the entire PSP refresher lasts one day this consists of a number of short classes. They in turn involve tutoring of a number of techniques.

[179] Officer B confirmed to me that no written materials were given out during PSP refresher training and any mention of ABD/ED/PA would have been spoken by instructors when they referred to medical implications of certain restraints. There was no reinforcement of concepts once the officers completed the one day refresher.

[180] I have considered this issue regarding training very carefully. It seems to me that, on paper at least, the PSNI had appropriate training material available containing sufficient information to alert officers to the risks of ABD/ED/PA. The issue, as I see it, was with delivery of this information. In 2013/2015 Service Procedure 59/07 and Appendix E were not made available to trainees as pre or post course reading material. Instead these issues were taught orally by instructors during practical training which necessarily involved tuition in a range of physical techniques. In my opinion this risked not placing sufficient emphasis on medical implications such as ABD/ED and PA. It would have been better if the reading material had been given in advance of the course as essential pre-reading or after the course as essential post-reading. This would have reinforced the importance of the written material.

[181] Officer A had not taken part in PSP refresher training since February 2013. I heard about the system in place that allowed officers to book a place on this training course. In brief, a series of reminder e-mails were sent to all officers informing them that their PSP training was due to expire and requesting that they register for a course. I was told that Ops Planning had a responsibility to arrange a place on a suitable PSP refresher course and each officer also had a personal responsibility to ensure that they attended at a course. In 2013 and 2015 there were no consequences for not attending a course. Indeed, the e-mail from ACC Martin, sent in 2014, made it clear that if officers did not complete a PSP refresher they would still be available for operational duty.

[182] Officer A received six automated reminders in January/February 2014. He told me at inquest he telephoned his Operation Planning Department ('Ops Planning') after receiving one of the reminders, he could not recall which. He was never booked onto a course and took no further steps to chase up this failure to book. I am satisfied this was a joint failure. Ops Planning should have booked Officer A onto a PSP refresher course. However, Officer A also failed in his personal responsibility to take all reasonable steps to ensure that he attended on a course and refreshed his training. I am not satisfied that Officer A discharged this responsibility by making one phone call to Ops Planning. He had a responsibility to make sure he was properly trained to do his job. As a result he was not sufficiently trained in restraint and recognition of ABD/ED/PA when he became involved in restraining Mr McMahon.

[183] Officer B also received six automated e-mails in October/November 2014. His PSP refresher expired on 25 November 2014. Officer B e-mailed Ops Planning on 2 November 2014 in response to an automated e-mail sent to him on 31 October 2014

and forwarded his reminder e-mail. No response was received and Officer B took no further steps to book himself onto a course. Similarly to Officer A, I consider this was a joint failure by Ops Planning and Officer B. I am also satisfied that as result of his failure to attend at a PSP refresher Office B was not sufficiently trained in restraint and recognition of ABD/ED/PA when he became involved in the restraint of Mr McMahon.

[184] Officer C had completed PSP refresher training in August 2015. This was due to expire in August 2016. On 22 July 2016 Officer C forwarded his reminder e-mail to Ops Planning. He got a further reminder on 29 July 2016 and also forwarded this to Ops Planning. No response was received and Officer C was not booked onto a PSP refresher course. Although this was a similar failure by both Officer C and Ops Planning there was only a short gap between his training expiring and the incident with Mr McMahon. Accordingly I am satisfied Officer C was sufficiently trained, in that he was broadly up to date with his PSP training.

[185] Support for my concerns regarding the quality of training on recognition of ABD/ED/PA can be found in the actions and evidence of Officer C. He had been PSP trained just under 13 months before the incident with Mr McMahon. He, therefore, had completed the various modules on restraint which involved, according to the evidence of Constable Hodgins, discussion on medical implications including ABD/ED/PA just over a year before he encountered Mr McMahon. I would expect him to have retained some of the PSP training knowledge if he had been trained correctly. Yet, on 8 September 2016 Officer C did not even suspect that Mr McMahon was suffering from an ABD. I appreciate that ABD is rare and I would not expect Officer C to have offered a medical diagnosis but his evidence was that he suspected Mr McMahon was under the influence of drugs and was not a medical emergency. The lack of any recognition of ABD/ED by Officer C is a poor reflection on the training he had received just over 12 months previously. I appreciate that Officer C may be an isolated case of a police officer not taking on board his training but I am inclined to think that the matter was systemic at that time since neither Officer A nor B recognised or suspected ABD or treated Mr McMahon as a medical emergency.

[186] Officer B in his evidence said he did suspect that ED may have been an issue with Mr McMahon but for a reason he could not explain he did not communicate these concerns to his colleagues. Neither Officer A nor B treated Mr McMahon as a medical emergency because, by their own acceptance, they did not suspect anything other than an individual who was under the influence of alcohol or drugs.

[187] I am satisfied that if the information contained within Service Procedure 59/07 and Appendix E had been communicated properly to Officers A, B and C in the 12 months before September 2016 they may have been in a position to at least suspect that the demeanour and behaviour of Mr McMahon was as a result of something more than just alcohol or drugs. They may have even been in a position to mention ABD/ED

to colleagues and discuss the potential for hospital treatment and been warned about the mechanics of any restraint.

[188] When Mr McMahon was brought to the Grand Opera House, Officers A and B attempted to talk to him and ascertain personal details. I am satisfied that at all times after this those officers dealing with Mr McMahon treated him as if he was intoxicated through alcohol and/or drugs. In other words, they did not realise he was suffering from ABD, should not be restrained and was to be treated as a medical emergency. I am satisfied that maintaining Mr McMahon in a seated position was appropriate. I am satisfied that on the first occasion Mr McMahon appeared to try and stand Officers A and B behaved reasonably in bringing him back to a seated position. Officer C then came to assist. At this stage a conversation should have taken place between all three officers regarding the risk posed by Mr McMahon. I was told that there was no communication between the officers.

[189] Officer A was positioned on Mr McMahon's left shoulder. He can be seen to be holding Mr McMahon's shoulder with no real indication of a particular plan for restraint. In the words of Mr Baskind, he is 'grabbing'. Similarly Officer C can be seen to be standing to Mr McMahon's front. It is not clear from the footage what his intention is, however, Constable Hodgins told me at inquest that Officer C was likely engaged in a tactical 'clock position' manoeuvre aimed at containing Mr McMahon. I agree with Mr Baskind that Mr McMahon should have been kept in the seated position. I also accept the evidence of Constable Hodgins that the officers would have been appropriately trained in techniques which would have enabled them to restrain Mr McMahon in a seated position.

[190] Mr McMahon came to be placed onto the ground because of lack of planning, risk assessment, communication and knowledge of appropriate restraint techniques. I cannot be sure if Mr McMahon was deliberately placed onto the ground or fell while struggling. Either way, the move to the ground was anything but properly planned.

[191] Mr Baskind told the inquest that when police officers are poorly trained or lack knowledge of appropriate techniques they tend to revert to 'grabbing'. That is an accurate way to describe how Mr McMahon came to be on the ground. He was grabbed by all three police officers, with no particular plan or restraint technique. While the restraint on the ground was extremely poor I am satisfied that the officers were justified in using a degree of force to restrain Mr McMahon. It is possible that if Mr McMahon had been allowed to flee he could have posed a very real risk to himself or road users. Great Victoria Street was beginning to get busy with vehicular traffic and pedestrians were in the vicinity.

[192] The force the officers used was not excessive. I do not underestimate how difficult it must have been to keep Mr McMahon under what the officers thought was

some degree of control. But, these efforts were made more difficult by a staggering and inexplicable lack of communication between the officers during the restraint. Officers A, B and C told the inquest that at no point during the restraint did they speak to each other about what they were doing. I find this to be astounding. Mr Baskind told the inquest that there should have been a 'control' officer whose responsibility it was to guide the restraint and monitor the detainee. No officer took control. The result was an uncoordinated restraint.

[193] I am satisfied that PSP training included elements concerning the importance of communication. I am, however, not satisfied that the officers were properly trained in the importance of having a 'control' or 'restraint' officer. Mr Baskind said this officer should ideally be the one closest to the detained person's head and more able to monitor their condition. He also said it was important that there were clear instructions communicated regarding any restraint and tactics as to how it was to be brought to a conclusion. At inquest Officer B accepted that he had the most service as a police officer. When I put to him that he should have been in control as the most senior person present he said that his view was that it was the initial crew who attended (Officer A and C) who were in control. Officers A and C did not appreciate this and did not think that Officer B should necessarily have taken control as the most experienced officer. This complete breakdown in any command structure led to the officers becoming engaged in a restraint with no single officer in command and, in my view, no 'end game' as to how the restraint might end.

[194] As Mr McMahon was being taken to the ground Officer A decided to discharge CS spray into Mr McMahon's face. Use of CS Spray in these circumstances was not just unwarranted but also irresponsible. Firstly, the training manual indicates that CS spray should not be discharged at a distance of less than a metre. It appears to me that Officer A was closer than a metre when he discharged his CS Spray. The manual also indicated that CS spray may not be effective on individuals who have taken drugs. All three officers suspected that Mr McMahon had taken drugs. However, the most important reason for not discharging CS Spray is that Officers C and B were always going to be highly likely to be affected by it. At the time it was discharged all three officers were involved in a close proximity struggle with Mr McMahon. Discharging it so close to colleagues was completely inappropriate. As it transpired Officers B and C were affected by the spray to the extent that they could not properly assess Mr McMahon's condition, administer CPR or communicate information to the ambulance crew. This was, even without hindsight, entirely predictable.

[195] When it was suspected that Mr McMahon was deteriorating an ambulance was called. This was appropriate. When it was suspected that he was having difficulties breathing he was moved to the recovery position and a request was made for a defibrillator to be brought to the scene. This was appropriate. Once it was established that Mr McMahon was not breathing there was a delay in beginning cardiopulmonary

resuscitation. This was as a result of two factors. Firstly, Officers B and C were incapacitated by CS Spray and Officer A was exhausted from the struggle with Mr McMahon. Secondly, Constable Gordon, whose subsequent efforts at CPR must be praised, misunderstood his first aid training and thought that a defibrillator should be applied prior to chest compressions commencing. As a result time was spent preparing for defibrillation when chest compressions could have been commenced. I accept the evidence of Dr Meng that this delay made no material difference. Mr McMahon was likely in asystolic cardiac arrest at this stage. This type of cardiac arrest, combined with an underlying metabolic disturbance caused by cocaine, meant that, in my opinion, the situation was not recoverable even at this stage.

[196] Nonetheless, Constables Gordon, Kingsberry and Mould performed effective CPR achieving a return of a pulse with no spontaneous respiratory effort. Professor Trinick at page 8 of his report indicated that "the success rate for out of Hospital resuscitation is close to zero. With trained personnel standing by it might be at best 5%. Unexpectedly the PSNI and Ambulance staff, by maintaining excellent CPR, had a return of spontaneous circulation." Despite the issue raised above regarding the commencement of chest compressions these officers deserve considerable praise and recognition for their efforts at attempting to resuscitate Mr McMahon.

Cause of death

[197] There was discussion about the formulation of a cause of death during the inquest. I am satisfied that the following formulation accurately answers the question as to how Mr McMahon came by his death:

> *1a. Hypoxic Ischaemic Necrosis of brain, Pneumonia and Multi-Organ Failure*
>
> *Due to*
>
> *1b. Cardiac arrest during restraint of an obese individual suffering from cocaine induced Acute Behavioural Disturbance.*
>
> *2. Rib fractures, Coronary Artery Atheroma.*

[198] The pathologists were all agreed on the primary cause of death (1a) and broadly agreed on the secondary causes (1b). There was disagreement between Dr Lyness on the one hand and Dr Shepherd and Dr Cary on the other. The latter did not feel that CS Spray, rib fractures or coronary artery atheroma warranted inclusion. Dr Lyness felt these conditions had an association with the death.

[199] I am satisfied that all rib fractures identified at post-mortem played some role in the development of a pneumonia and death. Accordingly I have included rib fractures

at part 2 – underlying conditions not directly causative. Similarly I consider coronary atheroma would have meant that Mr McMahon's heart may not have been as able to survive a cardiac arrest as well as a person's heart without 60% narrowing. In my opinion, this condition did not directly cause the death but is an underlying factor.

[200] I do not consider that CS Spray played any role in the death and accordingly it is not included in the formulation.

[201] At inquest there was also discussion as to what respective roles the ABD and the restraint played in the death. The pathologists were asked if Mr McMahon would have died absent the restraint. None of them, understandably, would give a definite answer. I am satisfied on all the evidence that at the time he interacted with police Mr McMahon was already very unwell. I agree with Dr Shepherd that he was likely suffering from a developing rhabdomyolysis, hyperkalaemia and kidney injury brought about by the ABD and cocaine ingestion. It is possible that he would have survived without the restraint but the restraint did occur and in my opinion this, in combination with the ABD, caused a cardiac arrest leading ultimately to Mr McMahon's death. The answer to the question - Would Mr McMahon have died without the restraint? – is, maybe.

Postscript

[202] In *R v Secretary of State for the Home Department ex Parte Amin*, Lord Bingham of Cornhill accurately described the function and duty of an inquest when discussing the State's obligation to investigate a death in accordance with an Article 2 ECHR. He said:

> *"The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life…It can fairly be described as procedural… such deaths (are) to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."*

[203] Can the relatives of Mr McMahon be satisfied that lessons have been learnt from his death? I believe that they can.

[204] During the inquest I heard evidence in relation to how police training and the requirement to undergo refresher training has changed since the death of Mr McMahon.

Chief Inspector Keers gave detailed evidence regarding the various changes to policy and structure.

[205] He said since 2018, the PSNI has implemented an online learning package specific to ABD. The package was introduced in line with a package which was created and distributed by the College of Policing for national delivery at that time. The PSNI e-package uses the College of Policing content (and which is updated following College of Policing updates, such as in 2020) which includes videos and information specific to ABD. The e-package provides guidance on the difficulties in treatment of ABD; the difficulties in recognising the condition and further advice on how to deal with someone exhibiting signs of the condition. It also teaches a new mnemonic "CAMERAS" for suspected cases of ABD, which means:

a. CONTAIN –avoid/minimise restraint where possible
b. AMBULANCE – Category 1 call
c. MONITOR – Vital signs
d. EXPLAIN – what you are doing to the person and their family (and listen), use friends and family to reassure
e. RELAY – Information to the ambulance and from the family
f. ABD=A&E Never custody or 130 Suite (Mental Health detention)
g. SEDATION - Healthcare sedation to reduce overdrive and restraint

[206] Chief Inspector Keers said one further safeguard now in place is a "Speak Up Speak Out" policy, which informs officers that the condition of ABD is difficult to recognise and, if an officer involved with a subject has reason to suspect that an individual is exhibiting symptoms of the condition, they should "speak up speak out" and treat the subject as a medical emergency. This policy focuses on the difficulty in recognising ABD during a real-time incident, when other factors might mask otherwise relevant warning signs.

[207] I was told that the learning e-package is to be completed annually and refreshed before the officer attends for PSP refresher training. Completion of the e-package is mandatory and controls are inserted so that an officer is obliged to watch the entire programme. I have been able to watch the new e-learning tool and it is my view that it is represents an excellent training tool when used in conjunction with physical PSP training. I was also told that officers who do not complete PSP refresher training will not be eligible for a compensatory payment in addition to their wages, thus there are now direct consequences for non-attendance.

Verdict

The deceased was Gerard McMahon.

Mr McMahon died on 8 September 2016 in the Royal Victoria Hospital Belfast.

Mr McMahon was single. He was born on 10 April 1980 in the Royal Jubliee Maternity Hospital in Belfast and previously worked as a motor mechanic.

He lived at 2 Strand Walk, Belfast, BT5 4TB.

I find Mr McMahon's cause of death to be:

1a. Hypoxic Ischaemic Necrosis of brain, Pneumonia and Multi-Organ Failure

Due to

1b. Cardiac arrest during restraint of an obese individual suffering from cocaine induced Acute Behavioural Disturbance.

2. Rib fractures, Coronary Artery Atheroma.