IOPC Independent Office for Police Conduct

DSI
Coldharbour Lane

Investigation into the police contact with Mr Ian Taylor prior to his death on Saturday 29 June 2019

> Independent investigation report

> Investigation information

Investigation name:	**Coldharbour Lane**
IOPC reference:	**2019/121679**
Investigation type:	**Death or Serious Injury (DSI)**
IOPC office:	**Croydon**
Lead investigator:	**Darryl Weaver**
Case supervisor:	**Amanda Spencer**
Director General delegate (Decision Maker):	**Catherine Hall**
Status of report:	**Final**
Date finalised:	**19 December 2019**

> Contents

> Introduction

> The purpose of this report

1. I was appointed by the IOPC to carry out an independent investigation into contact between police officers from the Metropolitan Police Service (MPS) and Mr Ian Taylor, prior to his death, on Saturday 29 June 2019 in Coldharbour Lane, Brixton. This matter was referred to the IOPC on Monday 1 July 2019 as a death or serious injury (DSI) investigation.

2. Following an IOPC investigation, the powers and obligations of the Director General (DG) are delegated to a senior member of IOPC staff, who I will refer to as the decision maker for the remainder of this report. The decision maker for this investigation is Operations Manager Catherine Hall.

3. In this report, I will provide an accurate summary of the evidence, and attach or refer to any relevant documents. I will also set out the evidence available relating to:

   (i) the nature and extent of the police contact prior to Mr Taylor's death, and

   (ii) whether the police may have caused or contributed to Mr Taylor's death

4. I will provide sufficient information to enable the decision maker to reach a decision as to whether:

   - there is an indication that any person serving with the police may have committed a criminal offence or behaved in a manner that would justify the bringing of disciplinary proceedings. If so, those matters will be investigated.
   - to make a recommendation to any organisation about any lessons which may need to be learned.

5. If the decision maker determines there is no indication of criminality or conduct, the MPS, who will have been sent the report, must then advise the IOPC whether or not it considers the performance of a person serving with the police to be

unsatisfactory, and what action (if any) it will take in respect of any such person's performance (if required to do so by the decision maker).

6. The decision maker will then consider whether the MPS determinations are appropriate, and decide whether to recommend that:

   (i) the performance of any person serving with the police is or is not satisfactory; and

   (ii) that specified action is taken is taken in respect of any unsatisfactory performance

7. The decision maker can ultimately direct the MPS to take steps to comply with her recommendation.

> The investigation

> Terms of reference

8. The terms of reference for this investigation were approved on Tuesday 16 July 2019. The terms of reference are:

9. To investigate:

   a) The police contact with Mr Taylor, following reports of a disturbance on Coldharbour Lane, on Saturday 29 June 2019.

   b) Whether, and to what extent, the police caused or contributed to the death of Mr Taylor.

   c) The interaction between officers and Ms A at the scene on Coldharbour Lane.

> Background information

10. The scope of this IOPC investigation concerned police contact with Mr Taylor following reports of a fight or disturbance on Coldharbour Lane, Brixton at approximately 5.54pm on Saturday 29 June 2019.

11. During the course of the IOPC investigation, further information became available which indicated Mr Taylor had been involved in a separate incident several hours earlier, at approximately 11.00am. Although this previous incident also occurred in the area of Coldharbour Lane and resulted in police attendance, there was no evidence of any contact between Mr Taylor and MPS officers. On Saturday 29 June, the only contact police officers had with Mr Taylor appears to have been from approximately 6.00pm onwards.

12. The incident at approximately 11.00am did not form part of the IOPC investigation.

> Other investigations

13. As Mr Taylor was believed to have been involved in a fight, he was arrested prior to his death along with two other men.

14. Following Mr Taylor's death, MPS detectives investigated the other men arrested in order to try to establish whether their actions may have caused or contributed to Mr Taylor's death.

15. At the time of writing this report, the police investigations are ongoing.[1]

> Family concerns

16. Following Mr Taylor's death, IOPC staff met with Ms A and Mr B. Ms A identified herself as Mr Taylor's partner and Mr B identified himself as Mr Taylor's cousin.

17. Ms A and Mr B identified two specific concerns, which they requested were addressed during the IOPC investigation. These concerns were:

    - Whether the police could have taken alternative steps to ensure Mr Taylor received medical treatment, for example by transporting him to hospital in a police vehicle.

[1] At the time of IOPC publication in August 2022, police investigations have now concluded.

- Whether there was a failure to communicate with Ms A following Mr Taylor's death.

18. These questions, whilst already covered by the terms of reference, are considered specifically in the analysis section of this report.

>Chronology

19. At approximately 5.54pm on Saturday 29 June 2019, the MPS control room received a 999 call from a man reporting a fight in his bar on Coldharbour Lane, Brixton. An MPS call handler created an electronic incident log, referred to as a CAD, to record details of the fight. Temperatures on 29 June had exceeded 30 degrees in London, and the weather conditions were still very warm at the time of this incident.

20. The call handler asked the bar owner to confirm how many people were involved in the fight and whether he had seen anyone with a weapon. The bar owner, whose first language did not appear to be English, stated he thought between 10 and 20 people were involved in the fight. The bar owner also stated he had not seen any weapons being used, before informing the call handler *"… somebody was with hammer on the street, he was with a hammer trying to hit people"*.

21. The call handler asked the bar owner if he could provide more details about the man with the hammer. The bar owner stated the man with the hammer was Black with a bald head, approximately 30 or 35 years old and wearing a white shirt and black trousers. The bar owner also believed the man with the hammer was on Coldharbour Lane and travelling in the direction of Kings College Hospital, which is approximately one mile away.

22. The 999 call from the bar owner lasted approximately two minutes and 40 seconds. The MPS call handler added the relevant information from the call onto the CAD.

23. MPS radio transmissions confirmed the details of the fight on Coldharbour Lane were transmitted to officers as an incident requiring an immediate response. The radio transmissions confirmed one suspect was believed to be armed with a

hammer. PC Sally Turner acknowledged the incident and stated she would attend alongside PC Matthew Casson.

24. PC Turner and PC Casson both provided witness statements as part of the investigation. Both officers stated they were working together in a marked police vehicle, with PC Turner as the driver. A radio transmission from PC Turner confirmed they were the first officers at the location. Shortly after arrival, PC Turner requested more police units to assist her.

25. At 5.56pm, an entry on the CAD confirmed CCTV operators were monitoring the fight, which was now noted to be outside the "*social club"*. The club referred to was the Domino club, a large building at the junction of Coldharbour Lane and Moorland Road. The CCTV footage confirmed PC Turner's police vehicle was on scene at 5.56.26pm.

26. PC Casson also recorded his interactions on a body worn camera. This footage shows PC Casson approach a group of four men stood around Mr Taylor, who was on the floor. Mr Taylor was a Black male with dreadlocked hair, wearing a dark jacket and light coloured trousers. PC Casson's footage shows PC Turner bend down towards Mr Taylor, who could be heard saying the word *"asthma".* The footage also captured Mr Taylor moving himself off the floor and walking a short distance before sitting upright against a wall.

27. PC Casson's body worn video also captured a Black man in a white shirt informing the officers they should arrest Mr Taylor. An unknown voice could be heard on the footage speaking about a stabbing, however the context and full content of this was not clear from the footage provided.

28. PC Casson stated, as he arrived at the location with PC Turner, he could see a Black man lying on the floor. PC Casson further stated, *"… I could see the man on the floor appeared to be in pain and some distress"*. PC Casson also recalled hearing someone shout, *"you need to arrest him"*.

29. At 5.57pm, PC Casson's footage shows Mr Taylor was interacting with PC Turner. PC Turner asked Mr Taylor on two occasions, *"where is your inhaler?"*

whilst PC Turner's hands moved around Mr Taylor's upper body, including inside his jacket.

30. At 5.57.21pm, four plain clothed officers in an unmarked police vehicle arrived to assist PC Turner and PC Casson. PC Benjamin Softley was one of the plain clothed officers and activated his body worn camera on arriving at the location.

31. PC Softley's body worn footage confirmed he assisted Mr Taylor alongside PC Turner. His footage captured PC Turner asking Mr Taylor about his inhaler. Mr Taylor replied he did not know where his inhaler was but appeared to point towards his jacket.

32. At 5.58.06pm, PC Softley's footage captures PC Turner placing Mr Taylor's wrists in handcuffs to the front of his body, following information that he had caused damage to a restaurant. The footage also captures PC Turner stating, *"you haven't got an inhaler on you ok. I will get an ambulance, breathe through your nose and out through your mouth".*

33. Radio transmissions confirmed PC Turner made the following request, *"… can I just get an ambulance here for an adult male around 40. He's having trouble breathing, said he's having an asthma attack".* An entry on the CAD timed 5.59.55pm confirmed a request had been made for an ambulance to attend Coldharbour Lane. The ambulance request noted *"chief complaint – difficulty breathing, asthma"*.

34. PC Softley remained with Mr Taylor and continued to try to speak to him. PC Softley reassured Mr Tayler that an ambulance had been called and was on the way. Mr Taylor appeared to make several comments about the handcuffs, which PC Softley explained needed to stay on and could not be removed. PC Softley clarified "*I need to find the hammer first… all I know is someone here might have a hammer so right now you have to stay in the handcuffs".*

35. At approximately 6.00pm, PC Casson received an update through his personal radio. PC Casson was informed two men standing close to the officers and Mr Taylor were involved in the fight and had been witnessed, by CCTV operators, punching and stamping on Mr Taylor. PC Casson stated he stopped one of the men, wearing a white shirt, and placed him in handcuffs. PC Casson recalled the

man in the white shirt stated he, "*had made a citizen's arrest in self-defence*" and *"*(Mr Taylor) *had had a hammer* ". The man in the white shirt also told PC Casson that Mr Taylor had stabbed someone earlier the same day.

36. The second man, wearing a purple shirt, was arrested a short distance away by another officer.

37. At 6.00pm, PC Louise Nottage and PC Jamie Crichton arrived at the scene. Both officers provided statements and had body worn video activated, which captured their interactions.

38. At 6.02pm, PC Softley's body worn video shows PC Turner informed Mr Taylor he was under arrest for possession of an offensive weapon. In her account PC Turner stated, *"as* (Mr Taylor) *might have been in possession of a hammer, I arrested him for possession of an offensive weapon".*

39. At approximately 6.03pm, PC Casson left the area with the man in the white shirt, whom he had arrested on suspicion of assaulting Mr Taylor. Throughout the time PC Casson was present, his body worn video appeared to show Mr Taylor communicating with officers and providing details about his condition. Although Mr Taylor was speaking to the officers he appears to have been struggling to get his words out and spoke in short sentences.

40. Between 6.00pm and 6.05pm, Mr Taylor appeared to continue to comment about his inhaler and the handcuffs. At 6.04pm, PC Softley's body worn video captured Mr Taylor stating, *"I can't breathe".* PC Turner responded to Mr Taylor *"you can breathe because you are breathing, but you need to breathe in through your nose and out through your mouth ok. I am helping you".* Mr Taylor also stated, "*I'm dying"* on a number of occasions and complained of being very hot. Body worn video shows the officers pulled Mr Taylor's jacket down and provided him with some shade by positioning themselves to block out the sun.

41. The body worn footage also indicates PC Turner and PC Softley continued to encourage Mr Taylor to sit upright, on a number of occasions psychically moving him into a sitting position however, Mr Taylor did not remain in this position and regularly returned to lying down on his side.

42. At approximately 6.06pm, body worn video captures PC Turner asking for an update on her request for an ambulance. Radio transmissions between PC Turner and the control room confirmed the following:

43. PC Turner – *"you got an ETA on LAS please?"*

Control room – "*umm, negative, as I say they are holding calls only for life or death, has gone through to them though, difficulty breathing"*

PC Turner – "*he is having very* (sic) *difficulty breathing, he has got a head injury where he has been stamped on the head"*

Control Room – "*will update them*"

44. Other radio transmissions confirmed, at the time PC Turner made her request for an ambulance, the ambulance service were experiencing a high demand with 170 outstanding calls across London. As a result, the ambulance service had advised there would be long delays except for the most urgent requests.

45. PC Turner stated she recalled waiting a very long time for an ambulance, and further stated she believed she repeatedly tried to get an ambulance to attend. PC Turner stated she did not remember exactly how many times she requested an ambulance. PC Turner also stated Mr Taylor remained breathing and coherent and he was able to speak with the officers.

46. Between approximately 6.03pm and 6.08pm, PC Crichton's body worn video shows he had been speaking with a man who made allegations Mr Taylor had stabbed him earlier in the day. PC Softley's body worn video confirmed PC Turner further arrested Mr Taylor on suspicion of GBH.

47. PC Crichton stated, on his arrival at Coldharbour Lane, he could see Mr Taylor was already handcuffed. As a number of officers were already dealing with the situation, PC Crichton stated he started to look for witnesses. PC Crichton recalled a man saying, "*that's the guy who stabbed me*" and pointed towards Mr Taylor.

48. At approximately 6.11pm, a number of officers, including PC Softley, left the scene with the man in the purple shirt. As the man was led away to a police

vehicle CCTV footage shows Mr Taylor's partner, Ms A, walk around the corner of Moorland Road onto Coldharbour Lane.

49. Ms A took part in a video-recorded interview with an MPS detective but chose not to provide any further statements to the IOPC investigation. A copy of her police interview was reviewed for the purposes of this investigation.

50. Ms A stated she and Mr Taylor left their home on Saturday 29 June in the early afternoon, approximately 2pm. Ms A stated she was sure of the time because they, *"had not too long had lunch"*. Ms A recalled being sat in her car just off Coldharbour Lane and described, *"… nothing but noise… it sounded like tables and bottles being smashed all over the place, a lot of screaming and then all of a sudden a lot of sirens"*. Ms A stated, after 10 minutes, a man she recognised told her she needed to go and check on Mr Taylor.

51. CCTV and body worn video footage captures Ms A approaching Mr Taylor and stating, "*you need it, haven't you got one on you…I'll get you what you need*". PC Turner informed Ms A that Mr Taylor did not have his inhaler and confirmed to her the ambulance service were, "*holding calls*". Ms A remained with Mr Taylor for approximately 20 seconds before walking away.

52. Ms A stated she approached Mr Taylor on the floor and asked him what was wrong. She stated Mr Taylor replied, *"I'm having an asthma attack"*.

53. At approximately 6.13pm, body worn video and CCTV footage shows Ms A returned to stand with Mr Taylor. PC Turner again confirmed an ambulance had been requested but there was a delay, as none were available. PC Turner explained Mr Taylor would be taken to hospital before being taken into custody to be interviewed about the incident. PC Turner also stated, *"we are waiting for an ambulance… we can't do anything, we have to wait"*. Ms A stated it would take her about 45 minutes to get Mr Taylor an inhaler, which PC Nottage acknowledged seemed a long time.

54. At 6.14pm, PC Nottage's body worn video captures her asking Ms A if Mr Taylor's name is *"Eustace"*. PC Nottage appeared to indicate the officers had already tried to establish Mr Taylor's name but had not been able to understand

what he told them. The body worn footage shows Ms A bent down and stated to Mr Taylor, *"she wants to know your name"*.

55. PC Nottage recalled trying to ask Mr Taylor what his name was. PC Nottage stated, after asking twice and not being certain of the response, she decided not to ask again. When Ms A arrived, PC Nottage stated she could tell Ms A knew Mr Taylor. PC Nottage stated she asked Ms A for Mr Taylor's name but was told, *"he will tell you when he wants you to know"*. PC Nottage further stated she explained to Ms A she had already asked for Mr Taylor's name, but had not heard the response. PC Nottage confirmed she was told Mr Taylor's name was Ian.

56. Ms A recalled a female officer asked her for Mr Taylor's name. Ms A stated she told the officer Mr Taylor's full name and watched her write the name down in a notebook. Ms A further stated none of the officers present asked for her own name and stated this was despite the officers knowing she was going to go back to her car to look for Mr Taylor's inhaler.

57. Body worn and CCTV footage confirm PC Nottage and PC Turner were the only two female officers present at the same time as Ms A. CCTV footage did not show PC Turner or PC Nottage writing in a notebook during the incident. PC Nottage provided a copy of her pocket notebook but no details relating to Mr Taylor were recorded. PC Turner's pocket notebook was not available during the investigation.

58. At approximately 6.17pm, body worn footage captures PC Turner asking if it would be possible for an inhaler to be brought to the location from a police station. PC Crichton stated this was not an option. At the same time, Ms A could be heard encouraging Mr Taylor to sit up as this would make him feel better. PC Turner instead suggested placing Mr Taylor in the rear of the police vehicle, stating there would be air-conditioning which would help Mr Taylor to feel better.

59. At 6.18.06pm, body worn video shows Ms A asked, *"will you be able to ring me and let me know what's happening"?* PC Crichton responded, "*when he goes to the police station, he'll have the opportunity to have someone called to let them*

know he's there so he can give you a call from there, alright?" Ms A acknowledged PC Crichton's answer and thanked him.

60. Between 6.17pm and 6.20pm, body worn video shows PC Turner, PC Nottage and PC Crichton assisting Mr Taylor by lifting him off the ground and placing him in the rear seat of a police vehicle. Mr Taylor continued to state he was going to die and the officers reassured him this would not happen. PC Nottage and PC Turner also sat inside the police vehicle with Mr Taylor. Body worn video confirms Mr Taylor was breathing and communicating at the point he was placed into the police vehicle.

61. Ms A recalled the officers placed Mr Taylor into the police vehicle; however, she was certain this occurred at 2.35pm. Ms A also stated she made a phonecall to Mr Taylor's cousin at the time he was placed into the police vehicle. Ms A was not able to find a record of this call on her mobile phone.

62. Between 6.20 and 6.24pm, PC Turner and PC Nottage remained inside the vehicle with Mr Taylor. Body worn video shows they asked Mr Taylor if the air conditioning was helping him. Any reply by Mr Taylor was not audible or visible; however, one of the officers stated, *"good, there you go"*. At 6.24pm, PC Nottage turned off her body worn camera.

63. Between 6.24pm and 6.28pm, there is no video footage of Mr Taylor. The CCTV camera monitored the incident until approximately 6.18pm, when Mr Taylor was placed into the police vehicle. Due to a fault, the camera only saved footage when a CCTV operator was actively monitoring the video feed. Police radio transmissions confirmed, at about the time Mr Taylor was being placed into a police vehicle, police and ambulance were alerted to a woman lying motionless in the road outside Brixton tube station.

64. PC Nottage stated, once in the police vehicle, Mr Taylor appeared to be more relaxed however, his breathing was still a concern. She also felt Mr Taylor's condition had not changed or improved during the time she had been present. PC Nottage also stated PC Turner continued to request updates on the ambulance and recalled PC Turner being told the ambulance should have arrived five minutes before, but was still 11 minutes away.

65. Radio transmissions confirmed PC Turner stated, *"any ETA on LAS? This man is having very* (sic) *he is having really* (sic) *difficulty breathing".* PC Turner was informed, *"They are on the way to you eleven minutes, that was at eighteen eleven* (6.11pm)*".*

66. A further radio transmission stated an ambulance had also been requested for the person in the road outside the tube station. The radio operator stated the ambulance service estimated a five minute timescale to attend the tube station incident.

67. Whilst in the back of the police vehicle, PC Nottage recalled Mr Taylor appeared to stop breathing and she was unable to get a response from him. PC Nottage further stated, *"although I could hear breath sounds it appeared he wasn't breathing".*

68. At 6.27pm, CCTV footage returned to view the Coldharbour Lane incident. The footage shows PC Turner exit the driver side of the police vehicle and move quickly around to the rear passenger door. PC Turner stated, once she opened the rear door, she could see that Mr Taylor was unresponsive and did not appear to be breathing.

69. PC Nottage and PC Turner stated they recalled an ambulance going past the police vehicle. PC Turner stated she, *"tried screaming and shouting… but it carried on driving past us".* PC Turner further stated she then attempted to remove Mr Taylor from the police car whilst shouting for help. PC Turner recalled a member of the public coming to assist.

70. CCTV footage confirmed, at approximately 6.31pm, PC Turner stood next to the open rear door of the police vehicle when she began to jump on the spot, wave her arm in the air and strike the roof of the police vehicle with her hand. The CCTV camera view widened to show an ambulance, with emergency lights activated, driving past the location in the direction of Brixton tube station. The behaviour of the ambulance did not change to indicate the driver had noticed PC Turner.

71. At 6.31.26pm, the CCTV footage shows PC Turner pulled Mr Taylor out of the police vehicle, causing her to fall to the floor. PC Nottage stated she was 'child locked' into the rear of the vehicle and had to climb across the seats to exit through the open door.

72. At 6.31.36pm, CCTV footage shows PC Turner, PC Nottage and a member of the public carried Mr Taylor away from the police vehicle and into the centre of the pavement. PC Turner stated she also removed the handcuffs from Mr Taylor's wrists.

73. Radio transmissions confirmed PC Turner updated the control room and stated Mr Taylor was now unconscious and not breathing, and again asked for an update on the ambulance. A transmission from the control room stated, *"breathing, that's all received we'll send it over now"*. In response to this PC Turner immediately stated, *"no not breathing, not breathing"*.

74. PC Turner stated, once Mr Taylor was removed from the police vehicle, she realised, *"this was potentially a proper medical emergency"*. In her statement, PC Turner accepted she felt unable to cope with the situation and believed she said something aloud which indicated she was struggling. PC Turner provided more context to these feelings, as she stated she had, *"performed CPR on duty seven or eight times since March 2018".* PC Turner believed, of all the times she had performed CPR in recent months, only two people had survived.

75. PC Crichton stated he had left PC Turner and PC Nottage with Mr Taylor and was further down Coldharbour Lane, attempting to take a statement from a witness. PC Crichton recalled PC Turner's radio transmissions and noted his concern, as PC Turner sounded *"alarmed"*. PC Crichton further stated he heard PC Turner, *"shout down the radio 'male unconscious not breathing'"*, causing him to run back to assist PC Turner and PC Nottage. At 6.31.56pm, CCTV footage confirmed PC Crichton ran towards Mr Taylor.

76. At 6.32.15pm, CCTV footage confirms PC Turner appeared to stand with her hands on her head and walked away from Mr Taylor while PC Nottage appeared to perform first aid checks. PC Nottage stated she placed her ear close to Mr Taylor and could hear sounds but did not believe Mr Taylor was breathing. The

footage shows PC Crichton took PC Turner's place whilst two further officers, PC Patel and PC James Southern, arrived in a marked police van.

77. Both PC Patel and PC Southern provided statements, which confirmed they had heard PC Turner's radio transmissions about Mr Taylor's condition. Both officers stated the sound of PC Turner's voice caused them to believe this was an urgent situation. CCTV footage shows PC Patel went directly to assist Mr Taylor, whilst PC Southern recognised PC Turner was very distressed and led her away from the situation before returning to assist with first aid on Mr Taylor.

78. The CCTV footage shows, between 6.32.08pm and 6.33.32pm, PC Nottage, PC Crichton and PC Patel all appeared to check Mr Taylor by placing their ear close to his head and looking down his body. The officers all stated they performed checks for signs Mr Taylor was responsive, which included using verbal commands, using pain and pressure to stimulate a response and checking Mr Taylor's breathing.

79. At 6.33.32pm, CCTV footage shows PC Patel commenced CPR on Mr Taylor. Radio transmissions showed an unknown male officer initially reported, "(Mr Taylor) *is breathing at the moment*". However, 58 seconds later, a further radio transmission confirmed CPR had started.

80. Between 6.33pm and 6.36pm, CCTV footage confirms PC Patel and PC Nottage continued to perform CPR on Mr Taylor. At 6.36.01pm, the first ambulance staff arrived at the location however the officers continued to provide CPR. At 6.42.43pm and 6.44.42pm, further ambulance resources arrived. CCTV footage continued until 6.53.55pm at which point Mr Taylor was still on the pavement being attended to by ambulance staff.

81. PC Crichton stated, at an unknown time, the ambulance staff were able to get an *"output"* from Mr Taylor, indicating there were signs of life, and he was taken to Kings College Hospital. PC Crichton and PC Nottage accompanied Mr Taylor to hospital and stated they observed hospital staff performing CPR again before another officer relieved them.

82. Scene photographs, taken by the MPS on the evening of 29 June, appeared to show parts of a badly damaged item, believed to be Mr Taylor's inhaler, scattered across the road on Coldharbour Lane.

83. Ms A stated, when she returned to Coldharbour Lane, Mr Taylor was no longer present and all police officers had left the area. Ms A stated she attempted to call police stations and hospitals in the local area to try to find out where Mr Taylor had been taken.

84. Ms A believed she was in the waiting area of Brixton Police station at approximately 10.00pm, when her friends informed her that Mr Taylor had been taken to Kings College Hospital. Ms A recalled arriving at the hospital at approximately 11.30pm; however, Mr Taylor had already passed away.

85. Mr Taylor was pronounced deceased in hospital at approximately 10.00pm on Saturday 29 June.

86. Ms A stated she was upset that no one had contacted her to tell her where Mr Taylor had been taken. Ms A believed she had given police Mr Taylor's full name and stated the officer's should have known his identity.

> Other evidence

87. PC Nottage and PC Turner were both asked to confirm their understanding of MPS policy about transporting detainees to hospital and any specific training they had received in relation to dealing with asthma.

88. PC Nottage stated she did not believe she had received any training about dealing with an asthma patient. PC Nottage further stated, "*apart from trying to ensure anybody who is suffering an asthma attack is looked after properly in terms of their ability to breathe I am not sure what else can be done where there is a clear and obvious asthma attack occurring"*. PC Nottage stated, although Mr Taylor was having difficulty breathing, she did not consider this was *"extreme difficulty"* until the point his condition deteriorated inside the police vehicle.

89. PC Nottage also stated she never considered taking Mr Taylor to hospital, as she did not feel this was in line with any policy or guidance. PC Nottage believed, where a person was under arrest and in handcuffs, they should be taken to hospital in an ambulance. PC Nottage did state she could think of some very serious situations where a suspect could be transported to hospital in a police vehicle. PC Nottage considered such action would require authorisation from a supervisor or duty officer.

90. PC Turner stated she did not recall having received any training in relation to suspected asthma attacks. PC Turner stated she would consider an asthma attack as serious but her own experience suggested there was little a police officer could do except to offer reassurance. PC Turner further stated she attempted to place Mr Taylor in the best position to help his breathing and continued to assess his condition.

91. PC Turner did not believe she ever considered taking Mr Taylor to hospital, as *"this is not approved practice"*. PC Turner further stated she thought there was a specific policy prohibiting the use of police vehicles to transport persons to hospital, especially those under arrest, with an exception for patients detained under mental health law which requires the approval of a duty officer or inspector.

> Policies, procedures, legislation and training considered

92. During the investigation, I have examined relevant national and local policies and legislation, as set out below. This will enable consideration of whether the polices were complied with, and whether the existing policies were sufficient in these circumstances.

> Metropolitan Police First Aid training

93. Ms Sue Warner, a senior first aid advisor for the MPS, provided a statement regarding police officer first aid training and expectations when dealing with individuals experiencing breathing difficulty.

94. Ms Warner stated the correct procedure for responding to an asthma patient is to sit them up in a comfortable position and allow them to take medication, if available. Where no medication is available, or if the medication does not help to relieve symptoms after five minutes, an ambulance should be called. The patient should be monitored and, if they become unresponsive and not breathing, CPR should be administered.

95. Ms Warner also commented on the standard operating procedure for transporting ill or injured patients in police vehicles. The procedure notes it might be appropriate to transport patient in a police vehicle, *"in exceptional circumstances"*. The procedure notes exceptional circumstances would usually only exist where, *"an ambulance is not available or is severely delayed and the* (police) *driver believes there is a very real risk of death or serious deterioration in a person's health if they are not conveyed to hospital immediately"*.

96. The procedure also notes the following points:

- The police driver must complete their own risk assessment on whether the patient needs to be transported to hospital in a police vehicle.
- The police driver must notify the duty officer or other supervisor of their intention to use a police vehicle to transport to hospital. An entry on the CAD must explain why immediate transport is preferred to waiting for an ambulance. The procedure is clear, however, that the police driver does not need to seek permission from a supervisor, simply inform them of their decision and the rationale.
- A person can refuse to be transported in a police vehicle.

97. Ms Warner provided a breakdown of the current ambulance response times as seven minutes for a patient who is not breathing, 18 minutes for a patient who is

breathing but requires urgent attention and 120 minutes for patients who require hospital assessment but are not urgent.

98. Ms Warner provided her own opinion on the situation as experienced by the officers dealing with Mr Taylor. She stated, *"an ambulance would have oxygen and medication to treat the asthma and transporting* (Mr Taylor) *to hospital may have delayed this treatment… officers would normally only consider transporting a casualty to hospital in a police car when they are informed of significant delays to the ambulance or none are available for some time"*.

99. Police officers receive training on identifying and responding to asthma attacks, which is part of a wider package on first aid. The learning objectives indicate the purpose of this training is to help officers understand the common causes or triggers of an asthma attack, to recognise the symptoms of an attack and understand how to treat an asthma attack. The guideline duration for this training is 20 minutes.

100. The training outcomes indicate the key points for officers to take away in relation to treating an asthma attack are to ensure the patient is sat upright and not lay down, the patient must self-administer their medication if they have it and, if there is no improvement after five minutes, an ambulance must be called. The training is clear that, where a patient does not have their medication or their condition is causing concern, an ambulance should be called immediately.

101. The supporting notes to the training confirms that an adult should be able to manage their condition. An adult asking for help, *"is often a sign that an attack is serious"*. The notes reinforce that a person experiencing an asthma attack should be reassured, seated in a comfortable position and told to breathe slowly and deeply.

102. A first aid training matrix, which highlights the different expectations of first aid training depending on the role a police officer or police staff is performing, confirms a police officer undergoes an initial three day training course on first aid which does not include any input on dealing with asthma. The first input officers receive about asthma occurs during a two day refresher course which is completed yearly.

> College of Policing, Authorised Professional Practice (APP) – medical emergencies during transport

103. The APP acts as the official source of professional practice on policing. Police officers and staff are expected to have regard to APP guidance when performing their responsibilities.

104. APP includes reference to transporting detainees to hospital, however, this in relation to detainees who are already in transit to custody. There is no reference in the APP to detainee's who are not physically in a custody suite or on the way to custody.

105. The APP guidance largely correlates with the MPS operating procedure and confirms use of a police vehicle to transport a person to hospital will be an exceptional situation, such as a known or anticipated long delay in the arrival of an ambulance. The APP also confirms use of a police vehicle should only be considered where a risk assessment indicates it is appropriate in the circumstances.

> Analysis

> Police contact with, and care of, Mr Taylor prior to him being placed in police vehicle

106. On Saturday 29 June, MPS officers were called to violent disturbance where, on arrival, Mr Taylor already appeared to be suffering an asthma attack. Information provided over the radio gave a description of a man believed to be in possession of a hammer. Although the initial description did not appear to match Mr Taylor, the officers were told Mr Taylor had been seen with a hammer and the allegation that he had been involved in an earlier stabbing was made at the same time.

107. PC Turner placed Mr Taylor into handcuffs due to concerns he may have been, or still be, in possession of a hammer, he may have caused damage to a property and the fact Mr Taylor was alleged to have been responsible for

stabbing another member of the public earlier the same day. The handcuffs were applied to the front, which would have allowed Mr Taylor to maintain some degree of movement and comfort.

108. PC Turner quickly identified Mr Taylor was having an asthma attack and she attempted to find his medication. After searching Mr Taylor and realising he did not have an inhaler with him, PC Turner made a radio transmission to request that an ambulance was called, providing relevant information including the fact Mr Taylor was having difficulty breathing due to his asthma condition. As a result, the ambulance service were made aware of Mr Taylor's medical needs within three minutes of police attendance.

109. No officer updated the control room to confirm they had not been able to find Mr Taylor's medication or inhaler. Whilst the policy and training does not indicate this information is required, explicitly stating it may have helped the ambulance service make informed decisions about Mr Taylor's needs. The decision maker may like to consider whether there is an opportunity for the MPS to reflect and review their guidance and training for officers when faced with a person suffering an asthma attack.

110. In an effort to improve his breathing, the officers decided to place Mr Taylor into a police vehicle. Body worn and CCTV footage confirms, from the point an ambulance was first requested to the point Mr Taylor was placed into the police vehicle, at least one officer continued to monitor him. In addition, the officers gave constant reassurance, encouraged Mr Taylor to sit upright, and attempted to shade him from the heat of the sun. Mr Taylor interacted with officers and appeared to be breathing, with his condition remaining consistent and with no indications he had stopped breathing or his asthma attack had become any worse.

111. Despite both PC Turner and PC Nottage believing they had not received any training on dealing with an asthma patient, all the officers involved in Mr Taylor's care demonstrated the correct approach in responding to Mr Taylor's needs, as highlighted by Ms Warner's evidence. Scene photographs confirmed a broken item, believed to be an asthma inhaler, was found in the area. This could have

belonged to Mr Taylor and might explain why PC Turner was unable to locate an inhaler on Mr Taylor.

> Police contact with, and care of, Mr Taylor after being placed in police vehicle

112. By 6.20pm, approximately 25 minutes after police had first arrived; Mr Taylor was sat within a police vehicle with two officers continuing to monitor him. Whilst Mr Taylor is not visible on video footage inside the vehicle, footage showing the officers assisting Mr Taylor to the vehicle confirms his condition appeared to be the same, as he continued to tell the officers he felt like he was "dying".

113. Inside the vehicle, one officer asked Mr Taylor if the air conditioning was helping his breathing and, while any response from him is not heard or seen, an officer stated, *"good, there you go"*. This appears to provide some weight to the statements given by the officers that they were monitoring Mr Taylor's condition and attempting to find ways to keep him comfortable and supported whilst waiting for an ambulance. The officer's words could also indicate they did not believe Mr Taylor's condition was deteriorating or that he was in urgent need of medical attention at this stage.

114. There are approximately four minutes without direct footage inside the police vehicle. The officers stated, during this period, they noticed a change in Mr Taylor's condition and believed he may have stopped breathing. CCTV footage confirmed PC Turner moved around the vehicle and leant into the vehicle next to Mr Taylor, before trying to attract the attention of a passing ambulance. Radio transmissions also confirmed PC Turner provided an update to the control room stating Mr Taylor had stopped breathing. A number of colleagues who heard this transmission stated they detected the panic and urgency in PC Turner's voice, and that this was out of character for her. The urgency and the fact her colleagues perceived a difference, may provide further evidence to support the fact Mr Taylor's condition appears to have suddenly deteriorated. PC Turner stated, she realised this may now be a, *"proper medical emergency"*.

115. Mr Taylor was removed from the police vehicle and PC Nottage began to check for breathing and to establish if he was unresponsive. The evidence indicates there may have been some confusion, as PC Nottage twice stated she heard breathing 'sounds' from Mr Taylor even though she did not believe he was breathing at that point. Further officers arrived quickly and checks, to determine if CPR was necessary, continued. There is evidence to support PC Nottage's statement about breathing 'sounds' in the form of a radio transmission stating Mr Taylor was breathing. However, 58 seconds later, at 6.33.32pm, CCTV footage confirmed CPR had commenced.

116. The CCTV footage shows there was a delay of 126 seconds between Mr Taylor being removed from the police vehicle and CPR starting. For a period of up to 58 seconds, Mr Taylor was believed to have been breathing. The first ambulance resources arrived at 6.36pm however, the CCTV footage shows the ambulance staff do not immediately take over; instead, the officers remained performing CPR.

> Should other options have been considered, such as taking Mr Taylor directly to hospital in a police vehicle?

117. PC Turner and PC Nottage both stated they did not consider taking Mr Taylor to hospital in a police vehicle as they believed this was prohibited by MPS policy.

118. PC Turner's stated belief appears supported by body worn video footage, which confirms she informed Ms A about the ambulance delays and stated, *"…we just have to wait"*. PC Turner did consider other options, as shown on body worn, when she asked whether it would be possible to bring Mr Taylor an inhaler from a custody suite. The fact PC Turner was considering her options might provide evidence to support the fact she had a genuine belief in the prohibition of transporting detainees to hospital in a police vehicle.

119. Evidence provided by Ms Warner confirmed the belief of PC Turner and PC Nottage was incorrect. MPS policy does not prohibit the transport of detainees to hospital in a police vehicle but does make it clear that such a decision will only be appropriate in exceptional circumstances and at the discretion of the police driver

responsible for the transport. Both the policy and Ms Warner agreed an example of exceptional circumstances would be a long delay in the arrival of an ambulance.

120. The evidence available to this investigation shows, from an early stage, there was a known backlog in ambulance wait times and this was transmitted to officers via radio. At 6.06pm, when PC Turner first asked for an update on the ambulance, she was told that the ambulance service were holding calls and, *"life and death"* incidents were being prioritised. PC Turner was not given any information indicating how long an ambulance might take to arrive. No evidence in this investigation has indicated any officer, or control room operator, suggested taking Mr Taylor to hospital or considered it might have been an option.

121. Before making a decision to transport an individual to hospital, the MPS policy requires the police driver to complete a risk assessment and determine that the circumstances suggest waiting for an ambulance would not be appropriate. Ms Warner gave an example of relevant considerations in the case of an asthma attack when she stated an ambulance would be equipped with *"oxygen and medication to treat the asthma..."*

122. A final consideration, which would have been relevant in this particular case, is that Kings College Hospital was approximately one mile away by road. Had the officers been aware the policy allowed them to consider taking Mr Taylor directly to hospital; this may have factored into their risk assessments. It should be noted, however, that both officers have stated they did not consider Mr Taylor a medical emergency until the point he appeared to become unresponsive.

123. The decision maker may like to consider whether it may be appropriate to consider learning for the MPS to ensure all officers are aware of the policy on transporting detainees to hospital in exceptional circumstances and whether a person who is suffering from an asthma attack and does not have their medication should be considered to fall within the definition of "exceptional circumstances".

> Was there a failure to communicate with Ms A?

124. Ms A stated she was unhappy that no one had contacted her to confirm where Mr Taylor had been taken. Ms A believed she had provided Mr Taylor's full name to one of the female officers, either PC Turner or PC Nottage, and had watched this officer write the name in their notebook. Ms A also acknowledged, however, that none of the officers asked her to identify herself.

125. Body worn video footage confirmed that, as Mr Taylor was placed into a police vehicle, Ms A asked if someone would be able to call and update her on what was going to happen. PC Crichton explained Mr Taylor would be allowed to have someone notified once he was in custody, which was acknowledged by Ms A and she thanked PC Crichton for his response.

126. None of the officers appears to have known who Ms A was and it does appear Ms A was not asked for her personal details or details of her relationship to Mr Taylor.

127. Ms A was also certain that a female officer had noted Mr Taylor's full name in a notebook, however there is no evidence to indicate this happened. Indeed, body worn video footage appears to indicate Ms A did not provide Mr Taylor's full name to the officers, with PC Nottage stating she was told the name 'Ian'. CCTV footage did not show PC Nottage or PC Turner using their pocket notebooks at any point during the incident. A copy of PC Nottage's notebook was seen which did not include any details relating to Ms A or Mr Taylor.

128. There does not appear to have been a requirement for officers to provide Ms A with the information she requested and, in any event, the officers did not ask for her personal details. PC Crichton provided a summary of the next steps, which would see Mr Taylor assessed at hospital before being taken to a police custody suite. Once in custody, it would be Mr Taylor who decided if he wished for someone to be contacted on his behalf.

129. The decision maker may like to consider whether, in the circumstances, the officers should have made efforts to identify Ms A and to confirm her relationship to Mr Taylor.

> Questions to be answered by the DSI investigation

130. At no point during the investigation was a determination made, pursuant to paragraph 21A of Schedule 3 to the Police Reform Act 2002, that any person serving with the police:

    a) may have committed a criminal offence; or

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

131. On receipt of this final investigation report, Operations Manager Catherine Hall, acting with the delegated authority of the DG under paragraph 24A(4) of Schedule 3 to the Police Reform Act 2002, is required to finally determine the two matters referred to above.

132. To conclude this analysis, I, as lead investigator, will consider the following:

    a) What evidence is available regarding the nature and extent of police contact with Mr Taylor prior to his death/serious injury?

    b) What evidence is available in relation to whether the police may have caused or contributed to Mr Taylor death or serious injury?

> What evidence is available regarding the nature and extent of police contact with Mr Taylor prior to his death?

133. The MPS were informed of a fight on Coldharbour Lane and police officers attended in response. On arrival of the first police unit, Mr Taylor was already on the floor and indicated he was experiencing an asthma attack. Officers remained in close proximity to Mr Taylor, as he had been placed in handcuffs following arrest on suspicion of committing violent offences.

134. PC Turner requested an ambulance for Mr Taylor when she was unable to find his inhaler. PC Turner, along with other officers, monitored Mr Taylor and attempted

to help his condition by encouraging him to sit upright and to focus on his breathing.

135. PC Turner and PC Nottage remained with Mr Taylor; however, his condition deteriorated whilst he was sat in a police vehicle waiting for an ambulance. Police officers gave CPR until the arrival of ambulance staff.

> What evidence is available in relation to whether the police may have caused or contributed to Mr Taylor's death?

136. Police officers remained with Mr Taylor and, throughout the time he was in their presence, he appeared to be suffering from an asthma attack. His condition did not appear to improve and deteriorated to a point where he appeared to stop breathing after approximately thirty minutes.

137. At the time of writing this report, I have not seen a copy of the post mortem findings and I do not have any information on the medical cause of Mr Taylor's death. Having said this, there is no evidence that any action on the part of a police officer may have caused or contributed to the death.

138. There is, however, evidence Mr Taylor was suffering from an asthma attack for an extended period without access to appropriate medical care, which could have contributed to his death. Whilst the evidence indicates PC Turner attempted to ensure an ambulance attended the location, there was a significant backlog in emergency calls to the ambulance service. PC Turner and PC Nottage both incorrectly believed they could not have taken Mr Taylor to hospital themselves and, as a result, did not consider this option.

> Next steps

139. The decision maker is now required to reach conclusions about the investigation. The decision maker will consider the evidence with a view to determining whether the report indicates that any person serving with the police may have committed a criminal offence or behaved in a manner that would justify the bringing of disciplinary proceedings.

140. The decision maker will also decide whether to require the MPS to determine whether or not the performance of a person serving with the police is unsatisfactory, and what action (if any) the authority will take in respect of any such person's performance. If so required, the decision maker will then decide whether those decisions are appropriate, and whether to recommend (and potentially direct) that the performance of a person serving with the police is unsatisfactory, and, if so, the action (if any) that should be taken in respect of it.

141. The decision maker's conclusions will be recorded on a separate document.

142. The decision maker will also decide whether any organisational learning has been identified that should be shared with the organisation in question. The decision maker may like to consider whether there is potential learning for the MPS to ensure all officers are aware of the policy for transporting detainees to hospital in exceptional circumstances.

Independent Office for Police Conduct

DSI

Coldharbour Lane

> Independent investigation report
> Appendices

>Appendix 1: The role of the IOPC

The IOPC carries out its own independent investigations into complaints and incidents involving the police, HM Revenue and Customs (HMRC), the National Crime Agency (NCA) and Home Office immigration and enforcement staff.

We are completely independent of the police and the government. All cases are overseen by the Director General (DG), who has the power to delegate their decisions to other members of staff in the organisation. These individuals are referred to as DG delegates, or decision makers, and they provide strategic direction and scrutinise the investigation.

> The investigation

At the outset of an investigation, a lead investigator will be appointed who will be responsible for the day-to-day running of the investigation on behalf of the DG. This may involve taking witness statements, analysing CCTV footage, reviewing documents, obtaining forensic and other expert evidence, as well as liaising with the coroner and other agencies.

The lead investigator is supported by a team that includes other investigators, lawyers, press officers and other specialist staff.

Throughout the investigation, meaningful updates are provided to interested persons and may be provided to other stakeholders at regular intervals. Each investigation also passes through a series of reviews and quality checks.

The IOPC has three main types of investigation. This case was what we refer to as a Death or Serious Injury (DSI) investigation, which means any circumstances where, or as a result of which, a person has died or sustained a serious injury and:

- at the time of death or serious injury, the person had been arrested by a person serving with the police and had not been released, or was otherwise detained in the custody of a person serving with the police, or
- at or before the time of death or serious injury, the person had contact of any kind – whether direct or indirect – with a person serving with the police who was acting in the execution of his or her duties, and there is an indication that the contact may have caused – whether directly or indirectly – or contributed to the death or serious injury

The investigation aims to identify and obtain the available evidence regarding the nature and extent of the police contact, and whether the police may have caused or contributed to the death or injury.

The possible outcomes of DSI investigations reflect the fact that it is not an inquiry into any criminal, conduct or complaint allegation against any person serving with the police.

> Investigation reports

Once the investigator has gathered the evidence, they must prepare a report. The report must summarise and analyse the evidence, and refer to or attach any relevant documents.

The report must then be submitted to the decision maker, who will decide if the report indicates that any person serving with the police may have committed a criminal offence, or behaved in a manner that would justify the bringing of disciplinary proceedings. If the decision maker decides that there is such an indication, it will be investigated as a conduct matter.

The report will also be given to the appropriate authority (normally the police force), who may be required to determine whether the actions of anyone serving with the police were unsatisfactory and what action (if any) will be taken in respect of any such person's performance. The appropriate authority must inform the decision maker of both its decisions. Unsatisfactory performance will be dealt with through the police force's unsatisfactory performance procedure (UPP). UPP is generally handled by the person's line manager and is intended to improve the performance of both the individual and police force.

If the decision maker considers that the appropriate authority's response is not appropriate, the decision maker has powers to recommend or ultimately direct that the matter is dealt with by UPP. The decision maker will also decide whether to make individual or wider learning recommendations for any relevant organisations.

> Inquests

In investigations into deaths, the IOPC's investigation report and supporting documents are usually provided to the coroner. The coroner may hold an inquest, either alone or with a jury. This hearing is unlike a trial and is a fact-finding forum. A coroner might ask a selection of witnesses to give evidence at the inquest. At the end of the inquest, the coroner and/or jury will decide how they think the death occurred based on the evidence they have heard and seen.

> Publishing the report

After any possible proceedings relating to the investigation have concluded, the IOPC may publish a summary of its investigation report. Redactions might be made to the report at this stage, for example, to ensure that individuals' personal data is sufficiently protected.