Joanne Caffrey

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Joanne Caffrey. Expert Witness & Specialist Trainer.

Author of: 'Drink Driving. Police Custody Procedures. Safer Custody Safer Prosecutions' ISBN: 9798866033591

Author of: Drink & Drug Driving. Police Procedures. (Release date to be confirmed)

Expert Witness with Bond Solon Legal Training in conjunction with Cardiff University Law School.

I was a police officer for 23.5 years which included performing as a custody sergeant for 7 years and then designing and delivering police custody training. I was head of the specialist training team for Cumbria Police which included all police custody training, use of force and first aid training.

I have received national awards and recognition for designing police custody training for the 2006 Safer Detention & Handling of Persons in Police Custody. In 2008 and 2009 I was a National Training Awards winner concerning design and delivery of the original Professionalising Investigation Programme (PIP).

As an expert witness I have been engaged for more than 700 cases. My main areas of work are:

- **Deaths & serious injuries in police custody**
- **Police procedures from point of incident dispatch until person charged**
- **Use of force (all sectors)**
- **Drink/drug driving procedures**
- **Ligature deaths (all secure sector settings)**

I have provided my services for public inquiry, coroner, fatal accident inquiries, civil, criminal and misconduct cases. I have been engaged by coroners and legal teams representing the defence and prosecution/claimant. I have repeat business from the

Police Federation, Police Professional Standards Departments, Police Ombudsman agencies and the Crown Office agencies.

I still provide training throughout the UK concerning Police procedures, drink/drug driving and ligature deaths.

I was a guest speaker at the September 2024 National Police Chiefs' Council Custody Conference.

I was a guest speaker at the Independent Drug Expert Alliance (IDEA) 2025 CPD conference concerning drug intoxication and police custody.

I attended as a voluntary delegate of the 2025 police custody Criminal Justice Curriculum working group, chaired by the College of Policing custody lead, reviewing the custody training course objectives.

I have worked as an advisor for the BBC, STV and Panorama police investigations.

I have been engaged by the Public Inquiry into the restraint death of Mr Sheku Bayoh, during restraint by Police Scotland officers. I gave evidence over 3 days and my report can be viewed on the Inquiry website: https://www.shekubayohinquiry.scot/node/545

The approximate split of cases includes:

- Defence: 50%
- Prosecuting authority/Claimant: 40%
- Engaged directly by the Coroner or Public Inquiry: 10%

I attended the National Police Trainers (England & Wales) course from 19th May to 3rd August 1994, and returned from the course to work at Cumbria police training unit. In October 1994 I was awarded a City and Guilds Further and Adult Education Teachers Certificate. In October 1999 I received my D32/33 Assessor award through South Cheshire College, and national police training. In 2001 I attended the national police training OSPRE assessor course for assessing Constable to Sergeant promotion procedures. In 2011 I was awarded the level 4 Preparing to teach in the lifelong learning sector. In March 1996 I attended a Home Office 6 weeks train the trainer, police trainers programme, course for delivering Community & Race Relations training throughout the Home Office forces.

I am a qualified instructor for a variety of use of force topics. These include:

- Conflict management and de-escalation
- Self defence
- Close-quarter combat
- Physical intervention
- Handcuffs
- Soft-cuffs and soft restraints
- Emergency response belts
- SIA (Security Industry Authority) physical intervention skills (until 2022)

I hold BTEC advanced awards for:

- Self-defence instruction
- Safe and effective use of the emergency response belt
- Safe and effective use of restraint equipment
- Conflict management training
- Physical restraint instruction

I have trained Health Care Professionals (HCPs) for their role within a forensic, custody, environment which has included the assessments for fitness to detain, fitness to interview, custody care planning, bail risk assessment, the Road Traffic Act drink and drug driving procedures and working alongside police officers generally for detainee care.

Since September 2020 I have been registered with the National Crime Agency as an Expert Advisor for major crime investigative support.

From December 2020 I have released an 8 hour on-line, level 2, certified course: Suicide Prevention Awareness Programme Module: Managing Ligature Risks. This can be found at: https://totaltrainltdeschool.thinkific.com/courses/suicide-prevention-managing-ligature-risks-in-the-secure-sector This is designed for all secure settings including police, prison, immigration, secure transport, secure children accommodation, mental health units, hospitals, customs and military custody.

From December 2020 I have released a 6 hour on-line, level 2, de-escalation and conflict management course which can be found at:

https://totaltrainltdeschool.thinkific.com/courses/de-escalation-and-conflict-management This is designed for staff working within education, care, or the secure custody sector.

My nationally accredited training courses include:

- CPD UK 1 day drink/drug driving
- Level 2 OCN[1] drink/drug driving
- Level 3 OCN managing safer custody
- Level 2 OCN managing suicide and self-harm in custody
- Level 2 OCN manging the use of force
- Level 2 OCN mental health first aid
- Level 2 OCN appropriate adults
- Level 2 OCN stop, search and seize
- Level 2 OCN conducting ligature audits and risk assessments
- Level 2 OCN managing ligature risks
- Level 3 OCN managing ligature risks

Concerning drink/drug driving and procedures:

Drink/Drug drive procedures are part of the custody portfolio due to the station procedures. All pre-arrest contact is part of the 'safer custody' portfolio. The legislation under the Road Traffic Act is under the roads policing portfolio but overlaps with the custody portfolio.

When I was operational all station and hospital procedures were conducted by a sergeant, so every constable request was conducted by me when I was on duty. There was hardly a day without a station evidential procedure being conducted and I am likely to have completed in excess of 1000 MGDD/A evidential procedures. I have completed many roadside procedures over my career, and some hospital procedures. The statutory option used to allow a blood specimen to replace breath specimens under 50, so I have completed many MGDDB procedures with HCPs.

During my police service I trained as an intoxilyser trainer, completing the train the trainer course at National Police Training, Harrogate. I trained other custody sergeants how to use the intoxyliser and conduct station and hospital evidential

[1] OCN: OCN Credit 4 Learning

procedures, including all of the MGDD forms. There are three levels of intoxilyser users:1. Operator; 2. operator and force supervisor; and 3. company engineer. I was an operator and force supervisor. This provided me with additional machine access, and all machine errors had to be reported through me.

Following the adoption of 'safer custody' by 2006, the sergeant was commonly removed from the investigative process to keep them impartial and focused upon the care and detention of the detainee. I taught constables the roadside procedures. By 2006 I was teaching custody staff (sergeants and detention officers) the safer custody aspects of dealing with drink & drug driver cases, and about the supervision of constables at the station conducting such procedures.

I remained involved in custody procedure training and policy until 2013, when I left policing. I have published an article in the Expert Witness magazine concerning drink and drug driving (November 2021); written 2 books concerning drink/drug driving; and still deliver some training concerning the police procedures for drink/drug driving which have been independently reviewed and accredited.

Concerning Ligature Deaths:

Since 2006 I have trained staff concerning the management of ligature risks. This includes understanding what a ligature point is.

I have conducted custody ligature audits within police buildings and trained other staff how to conduct them.

I have conducted ligature audits within mental health community facilities and special schools.

I have trained trainers, and medical staff, within the secure sectors and care sectors for managing ligature risks and conducting ligature audits.

I have experience in providing expert witness reports for ligature deaths within the secure sectors and following police bail. (25 engagements as an expert witness as of January 2026)

I have designed, and had accredited a 24 hour, train the trainer, management of ligature risks and conducting ligature audit course. This course has been delivered within the UK and the Republic of Ireland.

I have repeat engagement by the Scottish Crown Office & Procurator Fiscal Service to investigate ligature deaths in secure settings and deaths through other reasons in police custody; and have given evidence within the Fatal Accident Inquiries.

For four years I have been engaged in the Republic of Ireland for training clinical and non-clinical trainers and managers in ligature management. These are front line staff in adult and children secure sectors.

Concerning deaths during restraints

I have been involved in a public inquiry, coroner's and criminal cases concerning deaths during restraints. These deaths have occurred in hospital settings, police custody, police arrest, and prison custody.

I have been engaged for restraint deaths during police, prison and mental health unit practices.

Use of Force

I have multiple engagements concerning use of force mostly by police officers, but also prison officers, SIA staff, hospital staff, service users and members of the public. My main area of work is the police use of force.

I am regularly used by Police Professional Standards Departments, the CPS and Police Ombudsman Agencies, in addition to the Police Federation. I attend criminal, civil and gross misconduct hearings.

The use of force should never be viewed purely as a technique, as a correctly applied technique does not evidence that the use of force was necessary, reasonable or proportionate. A technique may be applied correctly but may still be:

- Unnecessary
- Unreasonable
- Disproportionate
- Not the minimum amount of force
- Not accommodating medical or physical vulnerabilities or safeguards.

Likewise, just because a technique is used which is not an approved technique, does not mean it cannot be justified due to the level of imminent threat the officer faced at that moment. My main sector of work is the prevention of deaths/serious injuries during police custody which includes during physical restraints/use of force. Examples demonstrate that people can die, or be injured, during a correctly applied technique due to risks not being considered prior to the use of force; the safeguards and safety control measures not being applied for that person's demographics; or that person's individual risks not being taken into consideration. Alternatives to use of force such as pushing a person away is another viable option.

The Human Rights Publication: 'Equality and Human Rights Commission. Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions' Published March 2019[1] states:

- Page 7 "significant physical force may only be used to restrain: a) as a last resort, where there is no viable alternative; b) where there is a genuine belief that it is strictly necessary to prevent serious harm including the risk of injury to the person or others, or in limited cases, preventing a crime, disorder or damage to property."

My cases have covered England, Wales, Northern Ireland, Ireland, Scotland, The Isle of Man and Gibraltar.

All police officers are required to use the National Decision-Making Model (NDM) for all decision-making processes. This involves a set process to consider:

- Step 1 - Gathering of relevant information from reasonably available resources and the use of THRIVE[2]
- Step 2 - Considering threats and risks
- Step 3 - Considering powers and policy. APP condenses all of the different legislation and guidance into one policing document.
- Step 4 - Considering all reasonable tactical options and contingencies. APP will provide advice which should be followed unless the threat/risks justify

[2] THRIVE: Threat. Harm. Risk. Investigation requirement. Vulnerabilities. Engagement plan

deviation; or mandatory directives which the officer is expected to comply with.

- Step 5 - Reviewing actions. This applies to the officer themselves and also the safeguards such as the custody officer and the HCP.

For this purpose, the College of Policing Authorised Professional Practice is the central reference document for all officers to follow. The NDM and the Authorised Professional Practice should not be trivialised in their significance and relevance.

PACE Code C 3E states that: "The detention and custody Authorised Professional Practice produced by the College of Policing provides more detailed guidance on risk assessments and identifies key risk areas which ***should always*** be considered." And Code C 8C states: The Authorised Professional Practice "provides more detailed guidance on matters concerning detainee healthcare and treatment and associated forensic issues which ***should be read*** in conjunction with sections 8 and 9 of this code." This means that the College of Policing Authorised Professional Practice has a significant relevance within the policing response and decision-making process for any incident. The APP provides clarity for a number of 'risk areas' which are expected to be complied with unless an officer can justify deviation from. The Authorised Professional Practice should not be trivialised in its importance, and provides some 'mandatory' actions for officers to follow, and some 'advisory' actions if officers can justify deviation.

Deaths in Police Custody

Deaths in police custody may occur due to a combination of factors. I have been engaged for deaths in police custody where detainees have died in their cells. Common errors have included:

- Severe intoxication not being recognised as a medical risk
- Head injuries not being recognised as a medical risk
- Withdrawals not being recognised as a medical emergency
- Care plans and levels of observations not being correctly applied
- Rousing procedures not being conducted correctly

- Custody staff and HCPs not communicating effectively with each other
- Custody records not being a reliable source of risk and care information
- The HCPs not being brought to assess detainees for fitness to detain or review assessments
- Staff too ready to assume a detainee is feigning illness

The custody function is separate to the investigation, and the custody function's priority is the safety and wellbeing of a detainee. Custody staff are required to use the National Decision-Making Model (NDM) to collate information, assess risk and review reasonable tactical options. Custody staff cannot simply decide to ignore Authorised Professional Practice or SOP requirements.

Misunderstandings concerning the role and responsibility of custody staff are commonly seen in my cases where the custody sergeant may believe that a HCPs opinion is a directive. Ultimately the HCP and detention officers act on behalf of the custody sergeant. The HCP advises the custody sergeant. The final decisions remain those of the custody sergeant.

I have been involved with Gross Misconduct and Manslaughter investigations concerning deaths in police custody.

Disclosure

In 2013 I initiated a tribunal case against Cumbria Constabulary under the Equality Act for failure to make reasonable adjustments. The court found in my favour, and I was awarded compensation, however this does not affect my impartiality and duty to the court. I still work with police forces concerning my expert witness services and I offer my training services.

In May 2019, after giving evidence in a London coroner case concerning police actions, the coroner rang me to state there was no criticism of me or my evidence, and no adverse judicial comment, but she was going to exclude my evidence due to the issue of bias being raised, and as I was engaged else-where (In Ireland) I was unable to return to court that date to clarify the position. The coroner confirmed that my litigation case against Cumbria Constabulary was of a private nature and was excluding my evidence only because I was unable to return to the court to clarify the situation.

In February 2020 representation was made from the legal team representing the Metropolitan Police, concerning potential bias because of my litigation against Cumbria Constabulary. H M Coroner Andrew Harris, Senior Coroner, London Inner South concluded: “The Senior Coroner summarised the gist of these concerns for Ms Caffrey and she provided a full account, which satisfied the senior coroner that there was no reason to suspect bias or a real basis for suspicion of bias in giving evidence in cases involving other police forces. It was noted that the litigation had no relation to operational decisions of police forces. The account contained information of a private nature.” And “Neither she nor the senior coroner see any reason that she cannot continue to be instructed in safer custody and restraint cases in future.”

As far as I am aware, this Employment Tribunal has not been raised since 2020.