THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

Notice of Outcome of Misconduct Hearing and any Disciplinary Action Imposed

Name:	Laura MURRAY	Force Number:	5889
Rank:	Sergeant	Division	Reading

Case reference number: CM/5/20

Allegations subject of Misconduct Hearing:

BACKGROUND FACTS

1. Police Sergeant Murray joined the police service on 6 June 2005. She was promoted to Police Sergeant on 1 March 2015.

Training

2. Officers are trained in the use of the National Decision Model ('NDM'). This requires officers to:

   (a). Consider the Code of Ethics and the principles and standards of professional behaviour, and

   (b). Gather information and intelligence, and

   (c). Assess the threat and risk and to develop a working strategy, and

   (d). Consider powers and policy, and

   (e). Identify options and contingencies, and

   (f). Take action and review what happened.

   Officers are trained to continually re-assess an incident taking into account changes in the circumstances.

3. Prior to the 8 January 2020 Sgt Murray had received the following relevant training:

   (a). 1/9/08 – Custody Skills

   (b). 26/6/15 – Professional Decision Making

   (c). 3/8/15 and 24/11/17- Mental Health Awareness

   (d). 22/6/18 – Detention & Custody Programme

   (e). 10/10/19 – Vulnerability in Custody

4. Prior to the incident PC Cunningham had received the following relevant training:

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(a). 8/4/11, 22/5/15 and 28/12/17 Mental Ill Health Awareness

(b). 11/5/12 – National Decision Model

Training, Policies and Procedures

5. Police officers have a duty to keep themselves up to date with policies and procedures.

6. The College of Policing Authorised Professional Practice ('the APP') Detention and Custody – Response, arrest and detention provides that where staff encounter an incident they must make an immediate risk assessment of it. The risk assessment should include:

(a). gathering available information and intelligence, and

(b). a vulnerability assessment that takes into account:

i. the appearance and behaviour of the detainee, and

ii. any signs of illness or injury,

iii. their style and level of communication, and

iv. should include collaborative information from all sources and the circumstances and environment in which they were found.

7. The APP further provides that a detainee must be transported directly to hospital if

(a). They are or have been unconscious, or

(b). They are drunk or incapable, or

(c). They are believed to have swallowed or packed drugs, or

(d). They are believed to have taken a drugs overdose, or

(e). They are suffering from any other medical condition requiring urgent attention, or

(f). They are suffering from any condition that an officer believes requires treatment prior to detention in custody.

It further states that detainees suspected of swallowing unknown quantities of drugs should be taken to hospital immediately.

8. If a detainee exhibits any of the following symptoms or behaviours the officer responsible for the care of the detainee should consider immediate transfer of the detainee to hospital. These include:

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(a). unconsciousness or lack of full consciousness

(b). any confusion

(c). difficulty waking

(d). any vomiting (unexplained)

(e). abnormal breathing

(f). chest pain."

9. The APP defines someone as drunk and incapable if

(a). they cannot walk or stand unaided, or

(b). they are unaware of their own actions, or

(c). they are unable to fully understand what is said to them.

Drunk and incapable individuals require an ambulance to be called immediately.

10. Where it is determined that an individual is not drunk and incapable but it is suspected that they have consumed alcohol or drugs then they should be subject to checks ever 30 minutes and roused during each check.

11. The frequency of rousing advised by a healthcare professional must be adhered to unless the custody officer directs that rousing should be more frequent. The rousing procedure is as follows;

(a). Can they be woken? Go into the cell and call their name, shake them gently

(b). Response to questions – can they give appropriate answers to questions such as; What is your name? Where do you live? Where do you think you are?

(c). Response to commands – can they respond appropriately to commands such as; Open your eyes, lift one arm, now the other arm (see also PACE Code C and Annex H).

12. Where a detainee fails to respond to rousing officers '*must seek immediate assistance from an [Health Care Professional] or transfer the detainee directly to hospital*.'

13. The APP also states that, '*Where detainees are unusually quiet or snoring, this can be a significant indicator of risk*.' And that '*Detainees who are snoring may have an upper airway obstruction.*' It states that, '*Officers should rouse and check them at least every 30 minutes.*'

14. As a result of the matters set out above the Officers were fully aware of the risk to Mr Cameron.

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Background Facts (all times are approximate)

15. On 8 January 2020, officers were called to an incident involving Mr William Cameron and his partner, . At about 01:27:58 officers began to interact with Mr Cameron. Mr Cameron was plainly intoxicated. However, at that time, he could speak, stand and respond to questions.

16. Officers were aware that Mr Cameron was a known drug user. His presentation was consistent with someone who had taken drugs. PC Cunningham believed that Mr Cameron was under the influence of alcohol and/or drugs.

17. At 01:45 PC Sung arrested Mr Cameron. Mr Cameron was placed in handcuffs. Mr Cameron's presentation deteriorated.

18. Officers interacted with outside the entrance to Mr Cameron's flat. In the course of that interaction told the Officers that,

    (a). Mr Cameron had taken tablets.

    (b). He had a load of prescription tablets that he had bought earlier.

    (c). She would like them to check him.

    (d). He would take the tablets; he would take them all.

    (e). He had taken some tablets earlier.

    (f). He has a heart condition.

    (g). He was going to fit.

    (h). He was going to end up fitting.

    The officers did not seek to clarify or expand upon the information that provided to them. Nor did they state that they could not understand what she was saying. The officers took no steps to verify the information.

19. Mr Cameron's presentation continued to deteriorate whilst he was with the officers. The officers noticed this and commented that,

    (a). 'Go on Will you were fine 10 minutes ago. You wanted to go and walk your dog How can you go from walking dog to this Will?'

    (b). Come on keep on walking. You're doing pretty well. Come on we are doing pretty well.

    (c). Come on Will, you were willing to go for a walk with your dog

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(d). He was 'pretty much non-responsive'.

(e). Okay Will come on, come on, come on come on you were gonna walk your dog mere minutes ago

20. Mr Cameron was handcuffed and led to a waiting police van. He was drunk and incapable. There was information that he had swallowed tablets and that he had an underlying health condition. Mr Cameron should have been taken to hospital immediately or an ambulance should have been called to assess him.

21. At 01:59 the police van began its journey to Loddon Valley Custody Suite.

22. During the journey to the police van, Mr Cameron's presentation changed in that he became less vocal and no longer supported his own body weight. He required urgent medical care.

23. repeated her earlier comments to other officers at the scene. She told the officers that 'he's taken loads of pills', and that they were 'prescribed drugs'. At about 2:04 this information was passed, via point to point, to PC Cunningham. PC Cunningham was told, 'I'm not sure what you want to do with this information, but apparently William has swallowed a shit load of pills.'

24. PC Cunningham did not query this with Mr Cameron nor did he take any other steps to investigate the accuracy of the information. He inaccurately conveyed the gist of this information to PC Sung – he stated that Mr Cameron had 'pocketed a bunch of pills'.

25. Mr Cameron made no noticeable movements during the transfer to Loddon Valley. PC Cunningham did not conduct any, or any adequate, further risk assessment. Mr Cameron should have been taken straight to hospital. He should not have been taken to custody.

26. The police van arrived at Loddon Valley Custody at about 02:13.

27. On arrival at Loddon Valley Mr Cameron was limp and unresponsive. PC Sung told Sgt Murray that, 'We got a point to point from other officers on the scene, according to Theresa, even though she wasn't there, apparently he's pocketed some pills.' PC Cunningham then said, 'With that said, we haven't actually searched him because of all the crap that was going on and her coming and trying to be all stupid.' PC Cunningham neither corrected nor expanded upon this information.

28. Sgt Murray instructed officers to carry Mr Cameron to cell A05. Mr Cameron was limp throughout the process. He was unconscious/drunk and incapable.

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29. Once in the cell Mr Cameron was seen by a Health Care Professional. In the course of the examination the Health Care Professional said, 'He's had something nice.' Sgt Murray was present in the cell and did not ask what the Health Care Professional had meant by this.

30. When Mr Cameron was left in the cell he was not left in the recovery position. He was snoring.

31. Sgt Murray determined that there was '… no point putting him on thirty rousals cause we'll never wake him.' Mr Cameron should have been placed on Level Two rousing checks as a minimum.

32. At 2:28 Sgt Murray authorised Mr Cameron's detention.

33. At 02:31 Sgt Murray recorded on the custody record that Mr Cameron had not received his rights as he was 'unfit' and that he had 'likely taken drugs.' Sgt Murray further recorded that he was 'Under the influence of drugs and/or alcohol.' She wrongly placed him on a 30 minute care plan with Level 1 observations and no rousing.

34. At 2:58 the detention officer carried out a check by looking through the cell door spy hole. Such a check is unacceptable and the detention officer should have entered the cell. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

35. At 3:23 the detention officer carried out a check by looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

36. At 3:58 the detention officer carried out a check by looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

37. At 4.29 the detention officer carried out a check by looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

38. At 4:49 the detention officer carried out a check by looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

39. At 5.29 the detention officer carried out a check by looking through the cell door spy hole. The

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detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

40. At 6:00 the detention officer spent around 30 seconds looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing'

41. Mr Cameron should have been referred for a further medical assessment at this point. Sgt Murray had neither queried nor challenged the inadequate checks performed by the detention officer nor the repeated, inadequate entries on the custody record. She failed to seek medical attention or advice at or around 6:15.

42. At 6:28 the detention officer spent about 34 seconds looking through the cell door spy hole. The detention officer recorded this check on the custody record as, 'DP lying on the floor on his stomach, appears asleep, visible breathing' Sgt Murray did not challenge this.

43. It is very likely that Mr Cameron had suffered a cardiac arrest by this point.

44. At 6:44 Sgt Murray provided the following briefing about Mr Cameron,

45. 'Err five, we've got the lovely William. William Cameron. Erm he was a complete dead weight when he arrived. He'd clearly taken some drugs, erm he was carried into the cell, plonked onto the floor, searched. I don't think he had a clue what was going on, he's been snoring ever since […] Erm yeah HCP present during the search in the cell. Did a few obs and he was happy [illegible] I didn't bother putting him on rousals because you'd probably have to clobber him over the head with a bat to wake him up. Erm so he's been on [illegible] but he's been snoring away, hasn't moved not even a millimetre but but he's fine. Erm warnings for him, alcoholic, drug user, self-harm, liver and kidney damage, hepatitis, you name it. But so far he's been lovely, hasn't said a word.'

46. At 7:04 a different detention officer entered Mr Cameron's cell and tried to rouse him. Staff performed first aid upon Mr Cameron and paramedics arrived at 7:21. Mr Cameron's temperature was 30.4 Celsius. Mr Cameron was taken to hospital and declared dead at 8:16.

Particulars of Misconduct

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Sgt Murray, it is alleged that you have breached the Standards of Professional Behaviour in that you wrongly authorized Mr Cameron's detention, wrongly placed Mr Cameron on Level One observations with no rousing, failed to supervise the detention officer and to ensure the checks were carried out properly, failed to challenge the detention officer about the verbatim entries in the custody record, failed to reassess Mr Cameron, failed to request medical assistance when he had not been roused for 4 hours and failed to conduct adequate and/or appropriate risk assessments. In particular the standards relating to:

(1) ***Authority, Respect and Courtesy***
Your behaviour as set out in the Background Facts at paragraphs 29, 30, 31, 32, 33, 41 and 42 above has breached this Standard. You failed to perform your duties in an efficient, diligent or professional manner.

(2) ***Orders and Instructions***
Your behaviour as set out in the Background Facts at paragraphs 29, 30, 31, 32, 33, 41 and 42 above has breached this Standard. You failed to comply with the APP, Code C of PACE, and local policies and guidance.

(3) ***Duties and Responsibilities***
Your behaviour as set out in the Background Facts at paragraphs 29, 30, 31, 32, 33, 41 and 42 above has breached this Standard. You failed to carry out your duties and obligations to the best of your ability.

(4) ***Discreditable Conduct***
Your behaviour as set out in the Background Facts at 29, 30, 31, 32, 33, 41 and 42 above. and (1), (2) and (3) of the Particulars of Misconduct have discredited the police service and/or undermined public confidence in it.

It is alleged that these matters individually and/or collectively amount to gross misconduct, namely a breach of the Standards of Professional Behaviour that, if proved, is so serious that your dismissal would be justified.

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FINDING: Gross Misconduct

The hearing began with an application on behalf of the Appropriate Authority ('AA') to proceed in the absence of PC Cunningham who had failed to attend. He had previously been served with the evidence both by recorded delivery and personal service in August 2025 and informed of the hearing date by way of email. He had expressed his intent not to take part in proceedings and had failed to supply any response to the allegations made against him. In accordance with the guidance found in GMC v Adeogba [2016] EWCA Civ 162 1 WLR 3867 it was determined that the case shoud proceed in his absence. His behaviour was deliberate, voluntary and had thus waived his right to appear. An adjournment would not have secured his attendance and the delay to date, (with it being 6 years since the incident complained of) meant it would be unfair to all other parties, including the family of the deceased, William Cameron, to delay matters further. The Panel had 2 statements that the officer had made to explain his actions and the Panel would carefully consider these when assessing the case against him.

The second application, again made by the AA but on behalf of the IOPC, the Crown Prosecution Service and Prosecuting Counsel was to restrict any reporting of the hearing until after the conclusion of the criminal trial against Sean Cregg, the healthcare practitioner who was involved in the assessment of Mr Cameron upon his arrival at the Custody Suite. The application was that any reporting of the Misconduct hearing could prejudice the trial against Mr Cregg in particular because DS Murray would be a witness at the trial thus risking the quality of her evidence in the trial if the case against her was reported, and, secondly, because the CCTV evidence advanced in the Misconduct hearing would be the same evidence to be utilised in the criminal trial. On behalf of DS Murray, a neutral stance was taken. A representative from the BBC told the Panel that her employers were alive to the risks involved in reporting the case, that they had received advice from their lawyers and would tailor their reporting to minimise the risk to any prejudice to the criminal trial of Mr Cregg.

The Panel was mindful of Regulations 6 and 39 of the 2020 Regulations. Whilst the proceedings were issued under the 2012 Regulations, the more recent Regulations provided valuable guidance. Regulation 6, dealing with the Harm Test, states:

6. *Information in documents which are stated to be subject to the harm test under these Regulations must not be supplied to the officer concerned in so far as the appropriate authority considers that preventing disclosure to the officer is—*

(a)necessary for the purpose of preventing the premature or inappropriate disclosure of information that is relevant to, or may be used in, any criminal proceedings;

Regulation 39 (3)(c) states:

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(3) Having considered any representations received under regulations 33(8)(f), 36(3) and 36(5), the person conducting or chairing the misconduct proceedings may—

(c)in the case of a chair appointed under regulation 28(4), give such directions as they think appropriate prohibiting the publication of any matter relating to the proceedings.

Regulation 39 (7)(a) states:

(7) This paragraph applies to information in so far as the person conducting or chairing the misconduct proceedings considers that preventing disclosure of it to an attendee is—

(a)necessary for the purpose of preventing the premature or inappropriate disclosure of information that is relevant to, or may be used in, any criminal proceedings;

Therefore, taking all submissions into account, including the direction within the Home Office Guidance as to the centrality of transparency within the Misconduct regime, it was determined that the proper administration of justice must, in this case, take precedence over the importance of transparency and the ability of the media to report such proceedings. Accordingly, an order was made that:

1. That there be no publication of any matters from the gross misconduct hearing apart from the fact that:

a. PS Murray and former PC Cunningham's cases were considered at a hearing.

b. The panel's decision on case to answer and, if applicable, sanction.

2. That this restriction remains in place until the conclusion of the criminal trial relating to Mr Sean Cregg.

Thereafter the AA provided a detailed opening of the case, relying upon the documentary and video recorded evidence contained in the bundle provided to all parties. As no witnesses were deemed necessary in the interests of justice, the AA then concluded their case.

The evidence on behalf of the AA was contained in the bundle of documents submitted to the parties, containing CCTV and BWV evidence without any live evidence being called. The AA relied upon their opening submissions combined with this evidence.

The Panel heard from DS Murray. As a Custody Sergeant, as she was in January 2020, she agreed that she was responsible for the welfare of those in custody with the assistance of

colleagues. When Mr Cameron arrived at the custody suite, she was reliant upon the information provided by PC Sung, the arresting officer, and his colleague, PC Cunningham. From this was learned that Mr Cameron had been arrested for a domestic assault, that the officers believed that Mr Cameron was feigning unconsciousness as a form of passive resistance, with the term 'deadweight' being used, that he had 'pocketed' some drugs but had yet to be searched and that PC Sung believed that Mr Cameron would not have been able to ingest any drugs whilst he was in the rear of the police van. As will be described later, important information was not relayed. From here DS Murray's concern as to how Mr Cameron presented led her to ask the HCP on duty, Mr Cregg, to undertake an assessment of Mr Cameron and his fitness to be detained. She was present during the examination and, at its conclusion asked Mr Cregg 'Happy?' to which Mr Cregg responded in the affirmative and thus proceeded on the basis that Mr Cameron was fit to be detained and, from her point of view, believed that Mr Cameron was sleeping. The Panel noted that the examination included the HCP shining a torch light into Mr Cameron's face, a 'trapezius squeeze' the application of a pulse oximeter and the raising of one of his arms without any rousal being evidenced other than a groan and, DS Murray said, a 'wiggle of the fingers'. She advised officers to move Mr Cameron so that his body was fully on the mat within the cell and that he was lying on his front (notably, however, not in the acknowledged recovery position). She had a conversation in a back office shortly thereafter with, she said, Mr Cregg, where she opined that there was no point in conducting rousal checks for Mr Cameron every 30 minutes as he 'would never be woken' and Mr Cregg had said that he agreed. The audio could not present evidence that the voice, if indeed male, was Mr Cregg but as there was no evidence to the contrary (and despite the AA querying its veracity as no mention of this had been made in her initial statements) the Panel accepted her evidence on this latter point.

A custody record was then opened and it was recorded by DS Murray that Mr Cameron was under the influence of alcohol and later that he was under the influence of 'alcohol and/or drugs.' This becomes relevant when her knowledge of Mr Cameron's addiction is discussed later. She recorded that there would be observations every 30 minutes with an additional check of CCTV observation on the screen in the Detention Officer's room, albeit she did not check this at any time. No further checks were carried out by her or the HCP (even though it was open for him to do so) and this included the 4-hour check required by her Force policy.

When asked about her training and understanding of policy, she had said that she was unaware of the term APP or the contents of the guidance. Given her role as a Custody Sergeant, the Panel

found such admission very surprising. She thought that the guidance referred to at pages 443,444, 445, referred to situations where no HCP was embedded within the custody environment. She had the use of an HCP and indeed deployed him and was satisfied that this fulfilled her obligations. As for the rousals policy at p450, she said that she did not know that Mr Cameron had taken any drugs. When asked in cross examination as to her understanding of the situation when told of Mr Cameron 'pocketing' drugs, she did not think that this was possible as PC's Sung and Cunningham had been with him all the time (even though a capsule containing 2 tablets was subsequently found on him when searched). When asked if it was possible that Mr Cameron could have taken drugs before the officers met him, she said that if that had been the case, she would have expected them to find some packaging, an answer the Panel found odd and lacking credibility.

From the evidence of the BWV, it was obvious to the Panel that when PC's Sung and Cunningham began their interaction with Mr Cameron, he was under the influence of alcohol and/or drugs given his demeanour his speech and behaviour. What is also apparent is how after being arrested and being taken down the stairs and steps of his home, Mr Cameron's condition deteriorates. He begins having difficulty in walking, goes to the floor and remains still when by the police van, has to be physically lifted into the van and moved into a more comfortable position and, during the journey to the Custody centre, ceases to make any movement whilst in the rear of the van. PC Sung, who is driving, asks PC Cunningham if Mr Cameron was alright and if he was moving to which PC Cunningham replies 'Yes, he's alright.' This was either wilful blindness or hopeless optimism on the part of PC Cunningham exacerbated by the fact that Mr Cameron's partner, had told PC Cunningham that Mr Cameron had 'taken tablets..he's got a load of fucking prescription tablets that he bought earlier' and that he had a heart condition. Two officers who remained with were given further information by her. She told PC Smith that Mr Cameron had taken a 'load of pills' and he gave that information via person-to-person radio to PC Cunningham whilst he was in the van. PC Cunningham relayed this message to PC Sung as Mr Cameron having 'pocketed' a load of pills. Pc Cunningham never told DS Murray about what had told him and his failure to tell PC Sung what had told him led to PC Sung providing DS Murray with incorrect and incomplete information. It is very evident from the evidence that PC Cunningham should have ensured that Mr Cameron was taken to hospital, not the custody centre, had he followed Force policy. DS Murray in evidence opined that is what should have happened. Whilst it is open to speculation as to PC Cunningham's motives for his inaction, it was a clear and egregious breach of

professional conduct on his part and, in part contributed to the events in the custody centre. Also contributing to the ensuing events was the expressed opinion of the officers that Mr Cameron had not taken any drugs in their presence without seemingly considering the very real likelihood that he had done so before their arrival, and that the subsequent deterioration of Mr Cameron's condition was as a result of the effects of these drugs, and possibly alcohol, taking an effect on him.

Turning back to DS Murray, on arrival at the custody centre the CCTV clearly shows how Mr Cameron had to be carried from the rear of the van onto a mat on the floor of the garage and, at 2.17 a.m. his head flop in a manner which would belie the belief in him feigning unconsciousness, despite the views of those present.

DS Murray was present in the garage at this time but said that she did not see this movement. Her reaction to the officers telling her about their prisoner demonstrated her familiarity with Mr Cameron. DS Murray had known Mr Cameron for 20 years, arresting him, dealing with him in custody and exchanging conversation and greetings on the streets. She knew of his alcohol and drug abuse, saying she knew he took Class A drugs, although she did not know the latest position insofar as drug taking was concerned. Importantly, she told the Panel that Mr Cameron had never caused her any problems in the past nor had he ever presented in such a way as that night nor ever feigned injury. Had she followed the National Decision-Making Model, these facts and knowledge should have led her to make more detailed enquiries as to Mr Cameron's condition than she did and at least consider an immediate transfer to a hospital, where, of course, the available treatment would be much better and safer than that which an embedded HCP could provide. She demonstrated no professional curiosity.

Mr Cameron was then taken to a cell and DS Murray demonstrating some proactivity, sought the advice of the embedded HCP and asked him to examine Mr Cameron. It is noticeable again here that the HCP commented that Mr Cameron 'had taken something nice' and yet this did not lead to anyone seeking more details as to what he meant and what the risks were. Again, the Panel found it odd that DS Murray's claim that she thought that Mr Cameron was simply asleep given the actions involving Mr Cameron by being carried from the van, into a cell, handcuffed to the rear, being searched, rolled over, some clothing removed, having a torch light placed into his face, having a trapezius squeeze and yet there was no reaction or rousal from Mr Cameron at all other than a groan and, she said, 'a wiggle of fingers'. Given Mr Cameron's condition even upon arrest, it is inconceivable that Mr Cameron could continue to feign unconsciousness, had that been what he was doing, after such intrusive acts. Whilst appreciating DS Murray's point

about her role as a lay person as against the HCP's experience and qualifications, the Panel would have expected at least some questioning on her part as to the HCPs clinical assessment that Mr Cameron was fit to be detained.

There then followed DS Murray's decision not to have level 2 observations with 30-minute rousals. This was a fatal error and ignored the direction within the APP, (p450), as to what level of observations should be deployed in such circumstances. It is clear from the Custody Record and the handover that DS Murray believed, with good reason, that Mr Cameron had ingested drugs and/or alcohol and yet decided to deploy the lowest standard of observations albeit with a 30-minute check rather than 60 minutes. Given her knowledge of Mr Cameron, his presentation and the information to hand, however incomplete, she totally misjudged the health of Mr Cameron and did not choose to query the advice, for that is all that it is, of the HCP.

DS Murray in cross examination agreed that she should have treated Mr Cameron as drunk and incapable but she sought the advice of and deferred entirely to the HCP. The Panel had some sympathy with her view here as the drafting of the guidance (e.g pages 443 and 445), is unclear as it makes no mention of the presence of a HCP and thus, it could be argued quite properly that the presence of a HCP could provide medical assistance. Equally it could be interpreted as the AA sought to persuade the Panel, but any lack of clarity must be interpreted in favour of the subject officer.

Finally. the Panel found that DS Murray's attitude towards Mr Cameron and how he was to be treated was coloured by her familiarity with Mr Cameron and displayed a lack of rigour in her assessments. The Panel found her conversation with PS Allen at the handover at 06.48 a.m. recorded (p33) to be particularly telling. She said:

Err five, we've got the lovely William. William Cameron. Erm he was a complete dead weight when he arrived. He'd clearly taken some drugs, erm he was carried into the cell, plonked onto the floor, searched. I don't think he had a clue what was going on, he's been snoring ever since [...] Erm yeah HCP present during the search in the cell. Did a few obs and he was happy [illegible] I didn't bother putting him on rousals because you'd probably have to clobber him over the head with a bat to wake him up. Erm so he's been on [illegible] but he's been snoring away, hasn't moved not even a millimetre but but he's fine. Erm warnings for him, alcoholic, drug user, self-harm, liver and kidney damage, hepatitis, you name it. But so far he's been lovely, hasn't said a word."

This demonstrated to the Panel a level of complacency, carelessness and lack of seriousness in her dealings with Mr Cameron that night which led to the tragic death of Mr Cameron and found

that she was, in her evidence, seeking to blame others (and this may be correct) without any acknowledgment of her own shortcomings.

Therefore, taking all the evidence into account the Panel found that DS Murray did erroneously place Mr Cameron on level one observations without rousing, she also failed to reassess Mr Cameron at any time that night, failed to seek medical assistance with Mr Cameron being unresponsive after 4 hours and failed to conduct adequate and appropriate risk assessments to protect Mr Cameron and his health. The Panel did not find proven the allegation that DS Murray wrongly authorised Mr Cameron's detention. Given the circumstances of the arrest she rightly concluded that it was necessary to detain him in accordance with PACE1984. This would have been whilst the parties were still in the garage and Mr Cameron is on the floor. She instructs the officers to take Mr Cameron to a nearby cell, which in terms is the authorisation. This was at a time when she should have directed an immediate transfer to hospital but given the brief time involved the Panel could not be satisfied that DS Murray had breached any Standard. As the defence correctly submitted, this is an entirely different matter than the question of fitness to detain. The Panel also dismissed the allegations relating to the supervision of the Detention Officer and the failure to challenge the entries onto the custody record that he made. Again, we agreed with the defence that the Detention Officer was seemingly properly trained and appointed with no reason given as to why DS Murray should supervise him to the level suggested by the AA. Had there been concerns as to his performance (and the Panel was not told of such) then the AA's case may have had merit but absent this, the delegation of responsibilities was undertaken properly and, as any supervisor would do, monitoring would be by way of a form of dip sampling as opposed to the level of scrutiny suggested by the AA. The APP as referred to by the defence makes it clear that the duties of the Custody Sergeant relate to having responsibility and authority for the custody and protection of a detainee and the progress of the investigative process in the police station. PACE Code C states that tasks may be delegated to officers and staff and, this being the case, this must include the ability to do so in the expectation that the duties will be carried out to the requisite standard without highly intrusive and time-consuming monitoring.

THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

STANDARD(S) OF PROFESSIONAL BEHAVIOUR DEEMED TO HAVE BEEN BREACHED:

The Panel found that DS Murray breached the Standards of Professional Behaviour in respect of

Authority respect and courtesy

Orders and Instructions

Duties and responsibilities

Discreditable Conduct.

In assessing the level of misconduct, the Panel found that culpability to be high given that DS Murray's actions were deliberate and, whilst not intending harm to Mr Cameron, such harm was entirely foreseeable. Culpability is thus high as is the level of harm caused. Accordingly, the Panel finds that the breaches amount to Gross Misconduct.

THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

DISCIPLINARY ACTION IMPOSED:
The purpose of the misconduct hearing is threefold:

Firstly, to protect the public confidence in and the reputation of policing.

Secondly, to maintain the high professional standards by demonstrating to other officers that misconduct will not be tolerated.

Thirdly, to protect the public and/or officers and staff by preventing the officers from committing similar misconduct again.

In determining the appropriate sanction, we took into account the following matters:

CULPABILITY

- The conduct was intentional to the extent that she failed in her role as the leader of the custody suite and the staff therein and failed to make all necessary enquiries displaying a lack of professional curiosity and being over reliant on others particularly the HCP.
- Whilst there was no intent at all to harm Mr Cameron, she should have foreseen the risks to Mr Cameron's health and wellbeing and been more proactive than she was.
- DS Murray was in a position of trust as the Custody Sergeant where she was directly responsible for the wellbeing of Mr Cameron who was clearly in a vulnerable condition and was failed by her and others that night.
- Mr Cameron was very vulnerable and the officer failed abjectly in her duty of care and professional duties towards Mr Cameron.
- Her culpability is high.

HARM

- The death of Mr Cameron was as a direct result of her failures and such was an infringement of his right to life.
- The psychological distress that Mr Cameron's death that was caused to his family.
- Any death whilst in police custody would undoubtedly undermine public confidence in the police and raise concerns for those detained in custody by the police.

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THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

AGGRAVATING FACTORS

Sustained behaviour over a period of time.
She continued her conduct when she should have known the ongoing risk to Mr Cameron's health and wellbeing.
Vulnerability of Mr Cameron.
Significant departure from Force Policy and national guidance.
Scale or depth of national concern regarding deaths whilst in police custody.

MITIGATING FACTORS:

We agreed with DS Murray that she was not alone in her failings; others were also at fault particularly PC Cunningham, Mr Cregg and the Detention Officer, . However, this has to be balanced with the fact that it was she who had overall responsibility for the custody centre at the relevant time and a duty of care for Mr Cameron.
From the character evidence provided the Panel were very impressed with the qualities that the officer has displayed and her effectiveness as a serving officer. She is a highly committed and her commitment is even more praiseworthy when reading of her work since 2020 and the fact that she has not had one days' sickness in the intervening time.
The Panel was obviously mindful of the limited role of personal mitigation in the Misconduct regime.

We acknowledge the risk of 'double counting' in assessing the above factors and have taken this into account. The Panel considered carefully the defence submissions regarding the imposition of a Final Written Warning and saw some merit in this given her excellent work and the high esteem in which she is held within the force. However, the Panel had to bear in mind the purposes of the regime and did not believe that public confidence could be maintained nor the public be protected from such acts in the future by such a sanction.

As a result of this misconduct hearing the following was found and imposed with effect from today:

Dismissal without notice.

THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

REPRESENTATIONS BY LEGALLY QUALIFIED CHAIR AS TO PUBLICATION ON BARRED LIST

Legally-qualified chairs have a role to play in making representations at the conclusion of misconduct proceedings as to publication of the information set out in the Barred List Regulations. As part of their remarks at the conclusion of the proceedings, they may make reference to whether any of the following factors are likely to apply:

a) Would be against the interests of national security;

b) Might prejudice the investigation or other criminal or civil proceedings;

c) Would result in significant risk of harm to any individual, including the officer themselves.

The relevant authority will then include these representations in their report to the College of Policing.

The above misconduct hearing was concluded on:	12 – 15th January 2026
The tribunal:	Mr Harry Ireland
	D/Superintendent Andrew Alexander
	Ms Jane Charlton

Under Rule 4(2) of the Police Appeals Tribunals Rules 2012 an appeal may be made by:

(a) an officer other than a senior officer against whom a finding of misconduct or gross misconduct has been made at a misconduct hearing
(b) a senior officer against whom a finding of misconduct or gross misconduct has been made at a misconduct meeting or a misconduct hearing or
(c) an officer against whom a finding of gross misconduct has been made at a special case hearing

Under Rule 4(1) an officer may appeal to the Police Appeals Tribunal against the finding or the disciplinary action imposed as a result of that finding or both.

Under Rule 4(4) the only grounds of appeal under the Police Appeals Tribunals Rules are:

(a) the finding or disciplinary action imposed was unreasonable or
(b) that there is evidence that could not reasonably be considered at the original hearing which could have materially affected the finding or decision on disciplinary action or
(c) that there was a breach of the procedures set out in the Conduct Regulations, the Police (Complaints and Misconduct) Regulations 2012, Schedule 3 to the Police Reform Act 2002 or other unfairness which could have materially affected the finding or decision on disciplinary action.

A police officer may not appeal to a tribunal against the finding where that finding was made following acceptance by the officer that his conduct amounted to misconduct or gross misconduct as the case may be.

THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

Where the appeal is brought by a chief officer of police or an acting chief officer, the respondent shall be a person designated by the relevant local policing body. Where the appeal is brought by any other police officer the respondent shall be the Chief Constable.

A police officer who wishes to appeal to a tribunal shall give notice of the appeal within 10 working days beginning on the date on the first working day after he/she received written notice of the decision that he/she is appealing against. The notice of appeal shall be given in writing to the relevant local policing body. Upon receipt of such notice the relevant local policing body shall send a copy to the respondent and where the appeal is a specified appeal to the IPCC.

For any notice of appeal outside this period, see Police Appeals Tribunals Rules 7(1) to (5).

The tribunal may determine a case without a hearing if the appellant has so consented in writing.

The appellant has the right to be represented at a hearing by a relevant lawyer or police friend. Even if represented by a relevant lawyer, the officer may also be accompanied by a police friend. If he/she chooses not to be represented the hearing may take place and the appeal may be determined without representation.

Costs

It is drawn to your attention that paragraphs 15.1 and 15.2 of the Home Office Guidance regarding Police Officer Misconduct state that the fees and expenses of tribunal members will be borne by the local policing body. An appellant pays their own costs of the appeal unless the tribunal directs that the whole or part of his or her costs are to be paid by the local policing body. Where the tribunal decides to award costs in favour of the appellant, it is suggested that the tribunal sets out the reasons for this and identifies any lessons to be learned by the force as a result of the case.

SUBMISSION OF NOTIFICATION OF APPEAL (AND ALL SUBSEQUENT DOCUMENTATION)

Please note that all correspondence regarding Police Appeals Tribunal matters are to be submitted to:

PCC@thamesvalley.pnn.police.uk
or
The Police and Crime Commissioner
Thames Valley Police Headquarters
Oxford Road
Kidlington
Oxon OX5 2NX

THAMES VALLEY POLICE

Professional Standards Department

REGULATION 36 POLICE (CONDUCT) REGULATIONS 2012
(As amended by the Police (Conduct) (Amendment) Regulations 2015);

Signature of Legally Qualified Chair: _____

Date: _____

I Christine Bovingdon-Cox confirm that I have served a copy of this document on Laura Murray via email.

Signature: _____

Date: 21 January 2026