Wiltshire Police

RECEIVED
28 MAY 2019

Mr. I Singleton
HM Assistant Coroner for Wiltshire & Swindon
Coroner's Office
26 Endless Street
Salisbury
Wiltshire
SP1 1DP

Police Headquarters
London Road
DEVIZES
Wiltshire SN10 2DN
Telephone: 101
Email: [redacted]

Date: 22nd May 2019 Your ref: **Aiden Ridley** Our ref:

Reply contact name is: **Assistant Chief Constable** [redacted]

Dear Mr. Singleton

I have received your regulation 28 report following the conclusion of the inquest on 10th April 2019 into the sad death of Aiden Ridley; I again offer my condolences to his family and friends.

In your report you raised five matters of concern, namely;

1. The advice by the Police call handler not to turn Aiden over.
2. The Police call hander did not advise members of the public at the scene to seek advice from the ambulance service or to defer to members of the public present with medical training.
3. The guidance, training and supervision of the Police call handler was inadequate to enable the call to be dealt with effectively.
4. There was a failure to intervene in or correct the advice given by the call handler not to turn Aiden over.
5. The system that has been introduced since Aiden's death, of allowing 3 way calls between the member of the public, the police call handler and the ambulance service appears on the evidence heard at the Inquest, to have had little if any use. To what extent does the introduction training and the ongoing training of Control room call operators refer to it or demonstrate it in action?

1. The advice by the Police call handler not to turn Aiden over.

I understand that the issues surrounding the initial call to police made this particular case unusual, as it was not immediately clear that Aiden had been struck by a vehicle and the caller was reporting a road traffic collision.
In normal circumstances when a person dials 999 they speak to a BT operator, they are asked which service the caller requires, if it is a multi-agency requirement then the call would be put through to the primary agency but the operator would remain on the line to transfer the caller to the next emergency service.
As events unfolded and it became clear there was a casualty the call remained with the police as the BT operator had ended their call, there was no facility to transfer the call to ambulance on a priority line.
Police call handlers are not trained in first aid and do not receive any training to provide first aid advice. Following this incident clarity on the point of Police call handers providing first aid was sought from [redacted] the National Police Chiefs Council (NPCC) lead for First Aid. The reply from [redacted] was they should not provide first aid. This has been communicated to all staff within the Crime & Communication Centre where the call handlers work, and updated protocols now exist between the police and ambulance call centers are now established which I will detail in a separate point.

2. The Police call hander did not advise members of the public at the scene to seek advice from the ambulance service or to defer to members of the public present with medical training.

The fact that medical advice was provided by the call handler in this incident has been the subject of clarification as we sought national guidance from by [redacted] The advice we received back was that the police call handlers should not provide first aid advice or guidance as they received no formal training for this.
This advice has been communicated to all the staff working in the Crime & Communication Centre that handles all the calls and crime reports that they will not provide first aid advice or guidance during a call and that they will utilise established protocols to refer the calls on to the ambulance call center who have the training, databases and established protocols to provide first aid advice to the people reporting medical emergencies.
The manager of the Crime & Communication Centre retains the responsibility to ensure staff are aware of this and this has also been adopted in the training of staff.

3. The guidance, training and supervision of the Police call handler was inadequate to enable the call to be dealt with effectively.

This call was initially reporting a road traffic collision and this quickly developed into a medical emergency call that was not identified as such at the point the call came to the police. The training given to call handlers enables them to take control of the call and extract relevant information from the caller and remaining calm and reassuring. As information developed a call was made to ambulance by a colleague to ensure an ambulance was attending the scene which was within procedure.

The training of a police call handler does not include medical training and at this point I would reiterate the above points around the clarification on medical advice and established procedures we now have in place with ambulance.

The current leadership and oversight provided within the Crime & Communications Centre is that of an inspector, there will be one or two supervisors on the shift depending on the time of day and between 12-15 call handlers. The call handlers will monitor 5 different radio channels to cover the different community areas and specialist operations channels alongside taking calls from the public. The call handlers receive training before they commence the role and ongoing refresher training in certain areas.

The call handler could have requested assistance if they felt they required it, however when the call came in it was regarded as a road traffic collision on a minor road and would not require a supervisor for oversight. This may have been required if for instance it was a multi-vehicle accident on the M4.

The routine one to one monitoring of individual calls is not achievable between a call handler and supervisor. Structures exist within the teams for a supervisor to provide assistance and the assessment of calls forms part of the ongoing training for quality and standards assurance. As call handlers' training now clearly excludes the provision of medical advice and instead sets out a simple method for involving the ambulance service, there is no longer any substantial risk of call handlers giving incorrect medical advice. The instructions/training mentioned above are in place both for existing and new call handlers.

4. There was a failure to intervene in, or correct the advice given by the call handler not to turn Aiden over.

As mentioned, incoming calls are not all routinely monitored by supervisors. The layout of the call center means the Force Incident Manager (Inspector) has responsibility for up to seventeen members of staff who are either taking calls or dispatching units. The inspector may hear one half of the conversation as the operator is speaking. The inspector and supervisors have the ability to dip sample calls of call handlers but also have other roles and responsibilities which include assessing the current active logs across the county.
A supervisor could review or monitor the call if requested by the call handler.
It is routine within the Crime & Communication Centre to have up to 30 live incidents across the county over five different radio channels which places demands on all the staff.
As with any call center we record calls for training and also for evidential purposes, but we do not have the capability to routinely monitor all calls but have capability to allocate additional staff to an incident if required.

In the event that a supervisor is monitoring a call and he/she has significant concerns about the advice being given by a call handler to the caller, that supervisor is expected to take appropriate action. The supervisor has a technical facility to take over the call, where appropriate, or alternatively can speak with the call handler.

Following the changes in policy/training around call handlers giving medical advice, if a supervisor was monitoring a call and heard a call handler attempting to give first aid advice (where his/her training dictates that the ambulance call handlers should be involved instead), then the supervisor would be expected to take appropriate action to ensure the training/policy was followed.

5. The system that has been introduced since Aiden's death, of allowing 3 way calls between the member of the public, the police call handler and the ambulance service appears on the evidence heard at the Inquest, to have had little if any use. To what extent does the introduction training and the ongoing training of Control room call operators refer to it or demonstrate it in action.

The functionality of this system is a standard telephony conferencing. This is trained to all of our new starters as is all other Cortex / Telephony processes. It is fair to say that the set of circumstances relating to the road traffic collision report involving Aidan remain unusual.

As happened on this occasion the ambulance was summoned by another operator. Since this incident staff briefings have been sent out on a number of occasions reminding those 999 call handlers to use this process when the need arises. This system has been in place since 26th June 2017. The conference ability is tested on a regular basis, as has the phone number to Ambulance to ensure the call is answered swiftly.

A variety of training materials (including e-mail reminders about the police sent to staff) were provided by Wiltshire Police as part of the inquest; please let me know if you require further copies of these. Furthermore, as indicated during the inquest, further revisions of the relevant Force procedure on managing calls have now taken place in order to underline the policy to staff.

We are grateful for the opportunity to reflect on and set out the organisational learning arising from this inquest. As indicated at the inquest, we have also been in communication with the NPCC / College Of Policing in respect of the policy changes and will provide them a copy of this response.

Yours Sincerely

[redacted]
Assistant Chief Constable