Ian Singleton HM Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Constable Kier Pritchard** **Wiltshire Police** **Wiltshire Police HQ** **London Road** **DEVIZES** **Wiltshire** **SN10 2DN**
1	**CORONER** I am Ian Singleton Assistant Coroner, for Wiltshire and Swindon
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16/02/2016 Senior Coroner, David Ridley commenced an investigation into the death of Aidan David Ridley, 22 and an Inquest was opened by him on 7th March 2016. The investigation concluded at the end of the inquest on 21 March 2019. The conclusion of the inquest was that at approximately 20.43 on 12/2/2016 Aidan David Ridley was struck by a Rover 45 on Hook Street, near Marsh Farm Hotel, Royal Wootton Bassett. He was thrown onto the verge and died as a direct result of lack of oxygen from how he landed. Aidan died 3 days later on 15/2/2016 at Southmead Hospital, Westbury on Trym, Bristol. At approximately 20.43 on 12/2/2016 Aidan David Ridley was in collision with a Rover 45 on Hook Street near Marsh Farm Hotel, Royal Wootton Bassett. Aidan was crossing the road from the hotel to walk to his bus stop. He was wearing dark clothing. His body was thrown onto the grass verge and partially obscured by a metal 'A' frame road sign. He was discovered on his front, with his head tucked under his chest. This position caused his airways to be obstructed and affected his ability to breath. At the time the bystanders were instructed not to turn him over, Aidan was alive but not breathing effectively. Failure to move Aidan to open his airway contributed to his death. It was not appropriate for the police call handler to give advice not to move Aidan and this advice had a direct impact upon the action of members of the public at the scene. There was a failure to instruct caller(s) at an earlier stage to rely solely upon the advice of the ambulance service, or members of the public with medical training present. There was a failure to intervene and or correct the advice given by the call handler and the guidance and training and supervision of the police call handler was not adequate.
4	**CIRCUMSTANCES OF THE DEATH** Hypoxic brain injury Road traffic collision
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my

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	opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The advice by the Police call handler not to turn Aidan over. (2) The Police call handler 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 Aidan over. (5) The system that has been introduced since Aidan'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 induction training and the ongoing training of Control room call operators refer to it or demonstrate it in action?

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd June 2019. I, the Assistant Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Irvine Thanvi Natas, Solicitors, Weightmans LLP, Slater & Gordon Lawyers, South Western Ambulance Service, Independent Office for Police Conduct I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 9th April 2019 Signature for Wiltshire and Swindon