The Sheku Bayoh Public Inquiry

Witness Statement

Keith Colver

Taken by [redacted] 18th September 2024

Background information

1. My name is Keith [redacted] Colver. My date of birth is [redacted] 1969.

2. I have been in my current role as Clinical Governance Manager for the Scottish Ambulance Service for 10 years. I have been in the service for 31 years.

3. I joined the service in 1993 as an ambulance care assistant for a year. I went from care assistant to ambulance technician for three years, before becoming a paramedic. I became a paramedic team leader until 2002. I moved into a role as a rapid response paramedic team leader from April 2002 until November 2002. In 2003, I moved to Special Operations

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Response team as team leader. I was seconded to NHS Lothian as a paramedic practitioner from January 2004 until October 2005.

4. I moved on secondment to Stirling University as a research fellow for nearly three years, from October 2005 until January 2008. I was a Research and Development Officer within the Chief Scientist Office Nursing Midwifery Allied Health Professions Research Unit.

5. I was then a Special Operations Manager from January 2008 until August 2010, then Resilience Advisor from August 2010 until August 2014.

6. Finally, I moved into my current role in August 2014.

7. My paramedic qualification is still ongoing. In order to retain my paramedic registration (Health & Care Professions Council [redacted]) , I maintain clinical skills and do the occasional clinical shift.

Scottish Ambulance Service systems:-

8. I have been asked when MPDS and MTS would be used by call handlers and triage paramedics and nurses during clinical assessment. MPDS is the International Academy of Emergency Dispatch, which is the programme used by the call handlers within the Ambulance Control Centre ('ACC'). It's a licensed product, from a company which is based in the USA. We use this to triage all emergency (999) calls that come into the service.

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9. As with the majority of clinical guidance this process will have received clinical updates since 2015.

10. I am asked what the qualifications of a call handler within the ACC would have been at 3rd May 2015. We train all our call handlers ourselves following an approved course by completing an in-house training programme, including supervision. One of the attractions of MPDS is that it's protocol driven and can be used by trained non-clinical people. The call handlers will go through scripted questions within MPDS, and they have to follow that rigidly, and then that brings them to a diagnosis code. Then we allocate a response.

11. The Manchester Triage tool (MTS) is used for secondary triage.

12. MTS is used by clinicians within the control room. They can be paramedics or nurses. It's not scripted in the way MPDS is, but there are algorithms they can follow which will guide them to a working diagnosis to provide a treatment plan and advice.

13. As with the majority of clinical guidance this process will have received clinical updates since 2015.

14. I am asked when a call handler would escalate the call from MPDS to MTS. It would depend on the type of call. Some calls will not get referred for clinical advice, they'll just get an immediate response. In that case, the call handler can actually carry on providing advice, depending on the severity of the illness or injury. An example of that might be a cardiac arrest or a birth; the call handler would stay on the line with the person calling and provide telephone advice following the MPDS scripts. With MTS, it tends to be calls with a lower clinical acuity that would go to a nurse or a paramedic, and they would have a conversation with the patient, try and take a history, establish what's happened and use the tools within MTS to establish a working diagnosis and the treatment plan.

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15. I am asked, therefore, whether MTS would be used when an ambulance isn't required. It can be quite variable depending on demand. So, absolutely. Maybe if we don't think an ambulance is immediately required, we can direct it to our nurses and paramedics, or if the patient possibly needs more advice or if we're busy, so if demand's out-stripping the number of available resources. Essentially, it's helping us narrow and improve the focus on the reason for the call.

16. I am asked to confirm whether MTS clinicians could request an ambulance. Yes - they also have alternative pathways available to them from within the control room that they can sign post patients to.

17. I am asked whether the paramedics and nurses are specifically assigned to the triage team or whether all paramedics and nurses do a shift within triage. No, it's a specific role. Some of them may still do face-to-face clinical shifts, but the actual role itself is telephone remote consultation.

18. I am asked what qualifies the paramedics and nurses to work within SAS ACC. I'm not entirely sure of the background that would be, but I'm sure the backgrounds are appropriate to the advice that's being given. There might be some that come from an emergency medicine background. There might be some that come from a primary care background. The ACC Learning and Development Manager will be able to provide further details. [redacted]

Call handlers: 2015

19. I am asked whether call handlers and/or clinicians would have been trained to recognise the signs and symptoms of Acute Behavioural Disturbance ('ABD'). In 2015, there was no training provided specifically for ABD.

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20. I am referred to **SBPI-00670,** our first position statement response, which states that there were no specific pathways within MPDS or MTS on ABD. However, there were still pathways which could be used where an individual was suspected to be suffering from ABD. These are MTS Protocols (9) and (32) (see **SAS-00012** 2013 version and **SAS-00013** 2015 version). We have provided both because we cannot be certain which version was in use on 3rd May 2015, as **SAS-00013** was brought in May 2015, with no specific date recorded. Protocol 25 (**SAS-00018**) would be the appropriate protocol for ABD within MPDS – this is the most recent version of MPDS.

21. I am asked why there was not a specific pathway in place for ABD at 2015. I can only assume that ABD was an emerging presentation in 2015. What tends to happen with clinical guidelines is that they can lag behind what's being seen face-to-face, and you have to build up a body of evidence and review that evidence. That's the likely reason why there wouldn't have been anything in 2015.

22. I am asked if call handlers would be aware of ABD in 2015. I am referred to **SBPI-00670** where it states in response to question 5:

"There was no specific ABD guidance in the 2013 JRCALC guidance. The following individual guidelines included some limited, but useful advice for a range of similar situations where a crew could ask for handcuffs/restraints to be removed repositioned. A final decision would be made by the police."

In our response, we referenced passages from:

- *Trauma Emergencies, page 200 positional asphyxia* (**SAS-00003**)
- *Mental Disorder page 90 (reasonable and proportionate steps) and 91 (violence)* (**SAS-00004**)
- *Medical Emergencies in Adults – Overview, page 94 restraint* (**SAS-00005**)
- *Incapacitating Agents, page 435 NB Excited delirium* (**SAS-00006**)

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I am asked specifically whether call handlers would have had sight of these documents. No, the documents we've mentioned in response to question five, that's all the guidance that our face-to-face clinicians use. So, JRCALC, the Joint Royal College Ambulance Liaison Committee, that's the guidelines that our paramedics and technicians use. Call handlers won't refer to this.

23. I am asked who can be dispatched in response to a call to the SAS. From a Scottish Ambulance Service perspective, it's our core paramedics and technicians that we could send out in an ambulance or a response car. We would also have Special Operations Response teams which are more geared towards specialist incidents, you know, your major incident type scenario. So, not really this.

24. Specialist Operations Response teams could be dispatched to road traffic collisions where there's maybe difficulty extricating people, significant numbers of patients. Anything that's sort of out with the norm where it needs specialist skills for access and extrication, but the paramedics within the team, broadly speaking, have the same skillset as (core) paramedics responding in ambulances and cars.

25. We could also request, what you could term as, a 'flying squad' from some health boards. They were available in Edinburgh and Glasgow in 2015. These are a health board resource, not a Scottish Ambulance Service resource.

26. There are and there were different models of operation. So, for example, in the East, we would drive the response vehicle, but the clinical staff would come from the hospital. Whereas I think in the West, and in Tayside, the health board responders would drive the response vehicle. In the west, it was a similar setup to the east, but they actually did have teams standing by, that's a handful of resources across the whole of Scotland.

27. I am asked whether emergency medicine doctors could be dispatched at the request of SAS. Yes - depending on the information that's passed to us, we could request them, or a

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crew on scene could request them. That would be things like, maybe major trauma where somebody's trapped, if there's going to be a delay in time to hospital, or there's some treatment that will benefit the patient that's beyond the scope of practice of paramedics. I should have said as well in our response, we've obviously got our air ambulances crewed with paramedics as a helicopter response as well.

28. I am asked to consider what the call handler's response would have been had ABD been mentioned on 3rd May 2015. If ABD had been mentioned, and this is now hypothetical, this is guesswork, I'm not sure a call handler would have been familiar with that terminology at that time. I think there were a lot of different terms being used. What they would do is they would ask more questions to establish what the problem is and that would determine the response we provide.

29. I am asked to consider what the call handler's response would have been had the police ACR call handler mentioned Sheku's behaviour and demeanour, but not ABD. I am told that witness accounts state that he was unresponsive to verbal commands, unresponsive to deployment of CS and PAVA spray, he was then taken into a restraint. This is where my colleague, Isobel Donaldson, would be the expert. Clearly if you're saying the patient's unresponsive, that's going to trigger our highest level of response. So, it's not the ABD, it's not the restraint; it's the fact the patient's unresponsive that we would respond.

30. I am asked if someone displaying symptoms of ABD would have been escalated for further clinical assessment. I am asked to hypothetically consider this situation. In a situation such as that of the 3rd May 2015 where the patient is reported to be unresponsive then I anticipate that the call handler would stay on the phone to provide telephone advice while the ambulance crew are responding to the patient/incident. The challenge with that is if it's the police control room that's phoned our ACC, you've got a call handler speaking to a call handler in the police control who's not on scene. Then that can make it very difficult to provide advice.

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31. If we're told that a patient is not breathing, we will dispatch an ambulance and then still go on collecting information. So, it doesn't delay the response to the patient There's certain triggers that immediately we dispatch an ambulance. We don't delay that dispatch, but we'll carry on trying to gather information and provide advice.

32. I am referred to our answer to **SBPI-00670** Question (2). I am asked which pathway it would have followed on MTS where ABD was not mentioned, but where Sheku's disposition and demeanour was. I think that Isobel's best placed to answer that, but when you're saying unresponsive, if the call handler picks that up as the patient's unresponsive, so unconscious, that will be dealt with in one algorithm. Potentially, if they're unresponsive to PAVA spray, that's a different thing. It's quite difficult to say, but if it was an unresponsive patient, they would be a high priority

PS00218 - Transcript of calls between Police Scotland ACR and SAS ACC – 3rd May 2015

33. I am referred to page 2 and 3 of **PS00218** where it states:

"Nothing that I have been made aware of, unfortunately I have got no information obviously ***they are trying to restrain this male that has assaulted the police officer at the moment so there is not a lot of information coming through****."*

I further refer you to page 3 of the same document, where they state:

"Yes its out on the street, and I am now being asked for two ambulances, eh one for the ehm vic. one for the officer and one for the assailant."

I am asked whether the request for a second ambulance for Sheku, coupled with the mention of him having been restrained, should have triggered a set of questions about

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his condition. The situation we've got here is you've got the call handler speaking to a call handler or an officer in the police control room, so it might not be possible to ask all the key questions. The MPDS system requires answers to questions to inform the next question or stage. In this situation the SAS call handler is speaking to a call handler/police officer in the police control room, remote from the two patients they are requesting help for. To the best of my knowledge the MPDS is designed to triage one patient at a time. The call handler would obviously be able to speak to their supervisor and ask advice about this. On my interpretation of what's here, is that it's not a normal event. The police are requesting two ambulances. So, there's something significant or there's something unusual happening here. Again, this is one that Isobel can provide the detail on.

34. I am asked to confirm what the SAS call handler's response would be where there is a lack of feedback from PS ACR. No, because that could potentially waste time. You know, because from the information you've been provided, that's enough to work out what we need. There's potentially no point asking some of the questions to a person who doesn't know the answer to it, because they are not with the patient. They're obviously asking you about a knife. You know, that's going to be from an injury perspective and obviously for a scene safety perspective as well.

35. I am referred to page 10 of **PS00218** where the following passage appears:

"Male SAS: However, one of the patients isn't now breathing…

Female PS: CPR is happening at the moment by police officers

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Male SAS: CPR is on going

Female SAS: Yep

Male SAS: Yep okay that is grand, would, so the officers are obviously there doing that would you like me to give anyone a phone and offer advice…

Female SAS: … They have started CPR but do they need to speak to the ambulance or are they quite happy carrying it out, can you double check…

Male SAS: I could phone and just offer instructions over the phone but then I am sure they know what they are doing anyway

Female PS: I think they, they will know CPR but thank you for that anyway."

After Police Scotland declined the offer of CPR advice, there are no further questions asked. Should further questions have been asked? Should SAS call handlers ask further questions to inform the pre-hospital care by the responders? So, from what you have shown me here, my understanding of this is that the staff in the ACC – the Ambulance Control Centre – have offered to give telephone CPR advice, which is what we do for all members of the public. The police have said "No." You know, there comes a point where this is a dynamic situation and from our perspective police officers are trained in CPR, although it would be a highly stressful event for them. Performing CPR is not their day job. There comes a point in the call where you have to make a decision and they seem quite happy, and if they were concerned, they could always phone back.

36. More information is always useful, or more information can be useful, that's not going to affect the response of the ambulance. I guess if there was something in the further information that suggested an incident was more complicated or there were injuries that we might send more resources, but it's such a dynamic situation. We are relying on feedback from the police officers to inform the decision-making.

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37. There's a standard response to a cardiac arrest. And given the specifics of that incident, we may respond with additional resources. We're not going to scale down the weight of response, but we might scale up the weight of response. When available we aim to allocate three ambulance responders to all out of hospital cardiac arrests.

38. I am asked to explain the target response times for ABD as at 2015. Yes, that was contained within our response to Question 7 within the first position statement response. That would be potentially life-threatening. 8 minutes, which is an average response time.

SAS-00012 and SAS-00013 – MTS Protocols (9) and (32)

39. I am referred to the above noted documents which show two protocols: (9) Behaving strangely; and (2) Mental illness. I am asked to confirm, if possible, which pathway would be used for a suspected ABD. Isobel is the expert here, but I can give you my opinion not being trained in this. Looking at the top of the algorithm there, we see:

> *"Airway compromise or inadequate breathing, or shock, unconscious. Provide life support, maintain scene safety. Airway compromise."*

That appears to me it's a face-to-face now-- so this isn't a telephone advice. This requires a face-to-face ambulance and ED in less than 20 minutes. So that's why that's coming out.

Looking at 2.2:

> *"Airway compromise, inadequate breathing, risk of self-harm, airway compromise,"*

Again, it's face-to-face now, ED less than 20 minutes, so you're never going to go any further down the algorithm there.

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40. In reference to **SAS-00012** and **SAS-00013**, I am asked to confirm who would have likely been dispatched to a suspected ABD. In 2015, in my opinion, the term ABD would not have been widely recognised. We provide a response based on the information provided. In the case of ABD, it would be the information about the presenting symptoms that determine the type of response. For example types of injury, difficulty breathing or in the worst case a cardiac arrest. It would be a mix of both ambulance technicians and paramedics. So for example when responding to a cardiac arrest, irrespective of cause, we aim to get three people on scene. We always dispatch the closest resource with a defibrillator and also aim to get a paramedic on the scene. The paramedic and the closest person might be the same person, but we would aim to also back them up with two other people.

Responders: 3rd May 2015

41. I am asked whether SAS clinicians were trained to identify and treat ABD at 3rd May 2015. No, they were not. But they were trained to manage the individual or cumulative symptoms of ABD. Paramedics and technicians will treat the symptoms irrespective of the cause. You know, there could be several causes for a cardiac arrest. The crew will treat cardiac arrest.
42. As an example of potential symptoms of ABD, I am referred to the JRCALC Guidelines on ABD (**SAS-00007**). I am asked what the Service response would have been had Sheku been exhibiting some or all of the symptoms on page 4 of this document. I am asked how SAS clinicians would respond to these symptoms. With any scene, it's always about scene safety for the crew and the patient and any bystanders. It's about making that scene safe in the best way that you can possibly do. If there's a risk of violence or a threat of violence, either from the patient to themselves, from the patient to bystanders, the patient to the crew, we would always request the police. When trying to care for people presenting with these symptoms, it's all about de-escalation, remaining calm, one person talking to the patient, trying to get them to the patient place of safety away from harm. It's a dynamic situation and all our operational staff are taught how to conduct a dynamic risk

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assessment, which constantly changes through the incident. Looking through the list there, there's not a specific treatment that you would provide there. I mean, obviously if somebody's hot and they've got lots of clothing on, you would remove that if you could. If there's a restraint, if there's continued struggle in restraint to the point of collapse, you're going to try and de-escalate the restraint if you can and observe what's going on there. If then it is to the point of collapse, you would then deal with the collapse. But, no, it's just about making the scene safe, calming it down and trying to monitor and respond to the patient's needs.

43. If the patient is rapidly breathing, due to an anxious state you would try and get the patient to slow their breathing. Though it depends on the cause of the rapid breathing. It's at the back of your mind, you're trying to work out what is causing this. Is it a medical condition that's causing this? Is it a hypoxia or a lack of oxygen that's causing this, you know? Have they lost a lot of blood so they've not got as much oxygen circulating which makes them breathe quicker? Or is their heart not working as well as it should which is not circulating the blood well, which then would cause them to be breathless, or is it a psychological cause, or enhanced by drugs? At that point oxygen might not be required but we would be guided by the advice in the JRCALC guidelines
44. I am asked what treatments would be available where the individual was assessed to have been suffering from ABD at 2015. The crew of the responders, they'd always go through the C, A, B, C, D, E. They look for catastrophic haemorrhage, airway/breathing, circulation, then they would deal with anything that required treatment. If their oxygen saturation was less than 94 per cent, they would try and provide oxygen. You can't always do that, even with a patient presenting like this, but clinically as the SATS are below 94 per cent, that would indicate that they need oxygen, so we would provide oxygen. If we're able to get blood glucose, take a sample of blood, and their blood sugar was low, which could be a cause for abnormal behaviour, we could give a patient a glucose IV or use Glucagon. Again, that's in a compliant patient.

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45. I am asked whether intravenous sedatives were available to responders in 2015. Not for Scottish Ambulance Service staff, so not for paramedics. It's a real stepwise approach. With treating anybody, you start at the minimum amount of intervention that's required. Sedating somebody would be the last sort of option, if you could manage it another way. The majority of patients you could manage without sedation.

Call handlers: 2024

46. I am asked if SAS call handlers are now trained to recognise the signs and symptoms of ABD in 2024. I would have to defer to my colleague, Isobel, on this point. Briefly, however, if police mention ABD, call handlers have a protocol and I think ABD is mentioned within MPDS. I am referred to **SAS-00018** which is a screenshot of the computer system that call handlers use, MPDS. 99 per cent of the time, unless there's maybe an outage in the control room, the call handlers would be following this on a computer screen. It's an algorithm. So it's different depending on what the call handler selects in response to information provided by the caller on the other end.

47. I am now referred to **SAS-00014** which is the MTS protocol currently in use by nurses/paramedics for further assessment. It is not specific to ABD, but it would be the most relevant protocols for suspected ABD. I am asked whether nurses and paramedics within ACC are trained to identify signs and symptoms of ABD. I'm not aware of what training they get. Again, Isobel will be able to answer that in more detail. I don't know what training is provided when new guidelines come in. Broadly speaking, when we introduce new clinical guidelines, sometimes we'll provide training because we think it's something significant and new. Other times, there's a responsibility on the clinician to adopt it. And actually, if they're referring to the guideline that should prompt them anyway. So reading that box there, even if you don't know what ABD is, you can read the description and then come to the conclusion that it could be ABD. All the information that you need is on that page, but whether specific training is provided around ABD, I don't know. Normally when we implement a guideline, we'll tell people what the changes are.

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48. I am asked what the call handler's response would be now where ABD is mentioned by ACR or a police officer calling directly from scene. I am asked who would be dispatched and what the target response time would be. A call handler should be aware of ABD, because we've introduced an additional guideline within the control room, our own guideline, which I think we sent to you, which is **SAS-00002.** If ABD is mentioned by the police, call handler picks that up, they then flag that for review by a clinician. It would be transferred away from the call handler to the clinician, and they, the clinical advisor, would use MTS to then triage it. If there were any priority symptoms other than that, they, the call handler, would dispatch. If there was anything of higher concern at that point in the call that required an ambulance to be dispatched, we would dispatch an ambulance.

49. If the police came on and said: "We're dealing with somebody with ABD and they're not breathing." The not breathing would trump the ABD.

50. I am referred to **SAS-00014** which shows a red pathway. I am asked what CSDR and CSDA refer to. These are abbreviations for Clinical Services Desk Red/Amber. These are the override codes used by the clinicians.
51. I am again referred to **SAS-00014** which displays a yellow pathway. Within the symptoms box, it states the following:

"Head injury, unconsciousness, significant psychiatric history, history of overdose or poisoning, neurological deficit, moderate aggression or agitation, moderate risk of leaving before assessment."

It is explained to me that some of these could be early indicators of ABD, or that they could present similarly to some of the early indicators of ABD. I am asked how yellow calls would be ranked against red priority calls. Isobel would provide the way the clinical advisors can triage calls, but they can upgrade a call if the situation escalated. They

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could make that a red or a purple call. Isobel would provide you with the options there, and I think it is quite difficult to say categorically: "This is what would happen." But if they're considering ABD, you know, they're going to recognise that's potentially life-threatening. The call will be escalated rather than de-escalated.

52. I am asked to explain who would be dispatched to a call of an individual with suspected ABD in 2024. Isobel can confirm this, but it would be a paramedic response. We could also deploy a critical care paramedic if there's one available. Now, bearing in mind that, they're a rare resource. We only have a handful around Scotland, so the response is going to look different in different areas. That would potentially be an option.

53. It would also be an option to get a medical team, but the medical team might want to have more details from paramedics on scene before they mobilise. Then again, within all of this, it depends on the location. If somebody's very, very close to hospital, to the receiving unit but maybe our Critical Care responders are far away, or a medical team or our Critical Care paramedics, it's quicker just to take the patient to the hospital and that's possible; you would do that.

54. I am asked to explain the skills and qualifications that critical care paramedics possess that standard paramedics do not. I am also asked if they receive further training from the SAS. It's both and then it's stepwise, so the critical care paramedics can provide some sedation up to a certain point and then the medical teams, the doctors, they can fully sedate, anesthetise, a patient. Paramedics can only give Midazolam, which is used for sedation when there is an immediate risk of harm to patients or others.

55. It would have to be done with top cover support from our Critical Care desk or an appropriate medical practitioner, and that's supposed to provide a level of clinical safety when caring for a patient with this level of agitation, in circumstances with immediate risk of harm to patients or others. The reality is within the confines of this conversation with ABD is that the quantity that a paramedic would be able to give wouldn't likely be sufficient.

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We can give sedation to some patients, but it's probably not enough in this situation. The vast majority of your decisions as a paramedic are sort of autonomous on the scene following guidelines. This would be deemed as an unusual situation, a rare situation, and you would just have that professional-to-professional conversation. This is normal practice in healthcare.

56. I am referred to **SAS-00014** which is the latest version of MTS Protocols (9) and (32) (in the 2023 version, Protocol 32 is listed as Protocol 33). I am asked to compare this version with the previous versions in force (**SAS-00012** and **SAS-00013**). It is highlighted to me that the list of potential symptoms has been extended and a warning box with the definition of ABD added. I think that goes back to what I said earlier about how evidence has evolved. The evidence has evolved, the research has been done and then that gets put into practice and there's always a lag.

57. It is further highlighted that the number of options of where a patient can be conveyed has been extended. I am asked to explain this change from the previous versions of these protocols, specifically CSDR, CSDA and ED: 20 minutes. Sorry, I don't know what the options are, apart from ED: 20 minutes which would mean the patient should be conveyed to an emergency department within 20 minutes. My guess as to why this has been extended is that there are more options available to the ambulance service now. As the resources have increased, our service has developed.

58. Our control rooms in 2024 look a lot different to what they did in 2015. We now have more clinical resources within the control rooms. We have something called an integrated clinical hub. It's not that responding to calls was transactional, in that we received a call and then sent a response in 2015, it's just that we now have more clinical pathways to offer patients.

59. I am asked to explain how call handlers would use Protocol 25 MPDS (**SAS-00018**) in 2024. You'd have to ask Isobel how they would use that technically. What I do know is

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that using this, if the call handler identifies ABD, they would then move to our MPDS practice guideline for police calls, if it's a police call.

60. I am asked whether there is any difference in the handling of calls directly from scene versus via ACR. Yes, there is. They're different. If we're talking about a single patient episode, rather than an incident, it's always better to speak to the person on scene. Because then we can use the MPDS protocols, and they're designed to speak to the person or gather information from the person on scene and provide them advice. What I would say is that to a certain level, it's irrelevant what information is passed to us from the police control room or the police on the scene. If they say some key things, like the patient's not breathing or ABD, we will provide a response to that call but what we can't do is then continue to provide the telephone advice while we respond face-to-face to the patient with a paramedic and technician in a ambulance.

61. I am asked to clarify whether **SAS-00002** would be used for all police calls, or specifically when ABD is mentioned by a police-caller or ACR call handler. I'll have a look. My understanding of the protocol is if there's a police officer at scene, we deal with that, we treat that as we would a 999 from the public. Because that's what the system is designed to do. If it's from the police control room, we ask the key questions, but we can abandon those questions if the police say they don't need them. I would imagine if that's to a control room, that's what we'll be told. Though, Isobel is the expert around this.

SAS-00002: Calls made directly from scene to SAS – February 2023

62. I am referred to **SAS-00002** which details a pilot scheme on calls made directly from scene to SAS ACC. The pilot scheme was conducted in Lanarkshire. It is highlighted to me that the date of release is noted as TBC. I am asked whether I am aware if the policy was ever rolled out across SAS. It has been released, yes. I noticed that when I sent it to you. So yes, it's a live document.

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63. I am asked whether it has been adopted by Police Scotland. Yes, my understanding is that this is live and is being used at the moment.

64. I am asked when this document was first developed. I believe the document was co-produced with the police in the weeks before its launch in February 2023. Although I don't know how long this was in development.

65. I am asked whether the SAS have stipulated a preference of calls directly from scene versus from ACR. Yes, so I don't have the data on this. However, I did speak to some colleagues, and we still get a mix of calls. We'll get a mix from police on scene and through the ACR.

66. I am asked why this policy and accompanying guidance was introduced. It's about us being able to provide advice to the police officers on scene. I suppose it's providing parity of care to patients. If you're a member of the public and the police officer calls for an ambulance, potentially if they're going through the control room, you're potentially getting a different response than you are than if you dial 999.
67. I am asked whether SAS would have consulted with Police Scotland on this document before its release. Yes, this would have been a joint discussion. I would imagine through our normal working relationships, as we have with many organisations, the need would have been identified.

68. I have been asked to list any benefits which have been fed back as a result of this policy. Pragmatically, you would think it would improve patient care and also the experience of police officers on scene. Unfortunately we don't have any quantitative or qualitative data, but anecdotal feedback from some senior managers suggests the calls received from scene are minimal.

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69. I am referred to page 1 – 2 of the above noted document. I am asked to consider how ABD would be processed using this guidance, specifically whether the call handler would process ABD under Option 1 or 2. The document states that Option 1 will go to emergency qualified EMDs whilst Option 2 will go to HCP or SEND call handlers. SEND is Secondary Emergency Notification of Dispatch. It's an abbreviation of the protocol we use for police and fire controls where we accept that the information they have is limited to what they've been told from the scene. Questioning in the protocol is limited to priority symptoms and scene safety questions only. HCP is Health Care Professionals. I think that could go either way, realistically. It would depend on what the symptoms are and what the caller states. My understanding is that in the case of a reported and or recognised ABD it will then get through to a call handler supervisor and if they mention ABD that will just go in the same direction.

70. I am asked to explain what pre-arrival instructions are. Pre-arrivals, the pre-arrival instructions, are the advice we give to people while the ambulance is enroute. In the cardiac arrest, we would offer telephone CPR advice. If somebody's got a major haemorrhage, it's advice on how to treat that, how to position the patient, what not what to do as well. Again, that's all scripted.

71. I am asked whether there are any pre-arrival instructions for ABD. I don't know. That question would be best answered by my colleague, Isobel.

72. I am asked to note the benefits and impact of having pre-arrival instructions issued before a patient is brought into the ED. I am asked to provide my answer specifically to ABD, where possible. We don't have the data. But, broadly speaking, if you took a cardiac arrest, which I suppose is relevant to this incident, the sooner that somebody can get hands on the person's chest, the better. So, if nobody's doing that, we can provide advice on how to do that, and that can be started before the arrival of the ambulance. The data

Signature of witness ……[redacted]…….

clearly shows that that improves outcomes. So, the advice we give is all evidence-based through the Academy.

73. I am asked to explain what 'key questions' are. My understanding is that "key questions" are the questions listed in MPDS. So that, again, "Is the patient breathing?" It's your headline questions, and then you go into your subset of questions. They would run that through with the caller.

74. I am asked to confirm what a worsening statement is. That's a standard thing in healthcare that when you finish your consultation with a patient you always say to them, "If something worsens, phone us back."

75. I am asked whether there are specific worsening statements for specific presentations/suspected diagnoses. Again, Isobel will be able to provide exact answers. For an ACC call handler, I don't think so. But, obviously, in a face-to-face consultation you might say to a patient, "If X,Y and Z happens, contact us." Or anything else that gives you concern, but I don't think it's quite so specific from the ACC.

76. I am drawn to page 3 of the same document and to a specific section on ABD, where it states:

> *"An EMD who receives a call for a patient with excited delirium or ABD should continue to process the call using Protocol 25 but should notify their supervisor who should highlight the call to the Clinical Support Manager so that the call can be clinically assessed and appropriate acuity level can be allocated."*

I am asked to explain the role of a clinical support manager and how that role differs from the triage paramedics/nurses. The clinical support manager has oversight of the clinicians in the control room. So, they would prioritise that

Signature of witness ……[redacted]…….

call. It's all computer based in the control. So, the clinicians will just work on the flow of calls that come through to them, whereas with this situation the Clinical Support Manager is physically being told about this call and we'll highlight that and give it priority.

77. The Clinical Support Manager has to have an overview of priority cases and can be asked to provide further assessment where needed. The further assessment would be to establish whether there's any priority symptoms. I believe, the call wouldn't normally be transferred to the Clinical Support Manager to deal with, rather identify and then to one of the Clinical Advisors to action, but if they thought it was required, they could call back to give further input. Obviously, sometimes you can't call back, or they could make an assessment on the information that's been provided by the ACC call handler.

78. It is noted that **SAS-00002** is dated 2023. I am asked if calling directly from scene to SAS ACC was an option for police in 2015. I don't know. That would be a question for the police. If a police officer called 999 from scene, we would manage that call as we would any other call. I don't know what their protocol was, but the more normal route for calls would be to come through the police control room. From our perspective, in this instance, there is no need for a call from a police officer to be routed through their control room. If a police officer dialled 999 we wouldn't then ask them to make the request through their control room. We would deal with the call and respond to the information we are told and or gather from the police officer.

SAS-00003 – Trauma Emergencies – Adults 2013

79. I am referred to page 200 of the above noted document:

> *"NB **Restraint (POSITIONAL) Asphyxia –** If the patient is required to be physically restrained (e.g. by police officers) in order to prevent them injuring*

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themselves or others, or for the purpose of being detained under the Mental Health Act, then it is paramount that the method of restraint allows both for a patent airway and adequate respiratory volume. ***Under these circumstances it is essential to ensure that the patient's airway and breathing are adequate at all times."***

I am asked whether this guidance on restraint was adopted into practice by SAS at 2015. SAS have never restrained patients It's always been seen as the responsibility of the police. They're the experts in restraint in the context of these questions. We do use securing belts for safety, for example to stop people slipping or falling when on our carrying/moving devices e.g. stretchers and wheelchairs in the similar way that you would use a car safety belt. But we do not restrain people displaying violence or agitation. Did we provide specific training around that in 2015? I'm not sure. Are the risks of restraint something the crews would highlight to police officers on scene? You know, it is a conversation that could take place, but I can't say for sure. I would think there's a higher index of suspicion around the risks of restraint now amongst clinicians than there was in 2015, or 2013 when this guidance was issued.

80. This has not been specifically taught by the service to clinicians, but has been included in the electronic dissemination of updated clinical guidance to individual clinicians via the JRCALC App.

81. Of course, paramedic education has changed since 2015. In 2015, Scottish Ambulance Service trained all our paramedics, but we've now gone to undergraduate courses. In Scotland, there are five universities delivering the course. These are Health and Care Professions Council , commonly known as the HCPC,-recognised and endorsed courses, but we would have to check with them whether this is specifically trained and taught. We train all our technicians in-house. If we're taking technicians or paramedics from out with Scotland, transferring in, we will give them an induction programme, but this is not directly covered in the induction.

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82. I am asked whether call handlers would be aware of JRCALC Guidelines at 2015. No. The call handlers just follow the script on MPDS. Certainly, the mention of restraint wouldn't have triggered any follow-up questions about airways etc.

83. The police are trained in restraint and that's their area of professional expertise. So, we would default to them for advice on the best method of restraint. You work together with them. My personal experience is the police are very accommodating if you ask them, you know, "Could this be done this way?" or, you know, if we need to provide treatment you could ask the police to manoeuvre the patient or restraint to allow treatment to be provided.

84. If you had to provide treatment, and if somebody was handcuffed a certain way and that was preventing you applying a dressing you'd say, "Is it possible to reposition the handcuffs?" So, we can do that, and would work out a way to do it. So, in this situation we're talking about here, if we thought somebody's airway was at risk, the expectation is you would say to the police, if they hadn't spotted that themselves, that "I think their airway's compromised." It would then be up to the police to decide how they manage that because they're the experts on restraint. So, if a patient was bleeding and we hadn't spotted it, the police would tell us the patient's bleeding and they would leave it up to us to treat the bleeding. They wouldn't tell us how to treat it. The same goes for this situation. If we think the patient's airway is compromised because of the way they're being restrained, we'd say, "The patient's airway is compromised," and then you'd expect, through their training and education that they would be able to adapt. This forms part of the dynamic risk assessment that the SAS responders perform.

SAS-00007 – JRCALC Guidance on ABD - 2017

85. I am referred to page 1 of the above noted document, where it states:

"The clinician must take all reasonable actions to clinically monitor the patient throughout restraint where possible. Patient restraint time must be kept to an

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absolute minimum. The degree of restraint used must be justifiable, reasonable and applied for the minimum time necessary and proportional to the situation."

I am asked, in reference to the above-noted guidance, whether call handlers as at 2024 would issue instructions to verbally de-escalate the situation to the police. I would have to defer to my colleague, Isobel, on this. My understanding is that if the police phone us and they're restraining somebody, they are the professional group and we would not provide advice in the context of restraint and ABD. The only time I am aware of that we would provide advice is where we receive a call where a person is fitting, we would say not to hold them down or put anything in the mouth.

86. I am asked if verbal de-escalation would be used as a tool by responders. Yes, absolutely. You're always trying to de-escalate with any situation. You take that stepwise approach and if it's safe to do so, clearly if somebody's going to jump in front of traffic, or harm themselves, you might have to try and do something else. But, again, that would just be the minimum intervention required.

87. I am asked if verbal de-escalation is used in the management and treatment of ABD by SAS responders. Yes. That's our current practice is to try verbal de-escalation before moving onto other options.

88. That can sometimes mean different things. If the scene is physically safe, and the patient's safe, your verbal de-escalation can go over a longer period. Whereas, if the scene is dangerous, your verbal de-escalation might be much shorter before you have to step up the ladder.

89. I am asked whether there is a difference between the sort of instructions that might be issued to a member of the public and the police as regards restraint. With police officers, the restraint would generally be left with the police. I am

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asked what instructions might be issued to a member of the public that is restraining someone exhibiting signs of ABD. On the telephone advice, I don't know. I'd have to clarify that with Isobel. I think from my experience, you know, you would deal with that differently. When you arrive, if the police are on the scene, restraining somebody, your assumption is that the police are professionals, and they know what they're doing.

90. When you turn up at the scene and members of the public with good intent are restraining somebody, that's an entirely different situation where you're having to take control of that situation. All the things that we've talked about, your index of suspicion, which is an awareness and concern for potentially serious unseen injury or illness, is much more heightened, that harm could come to the patient as a result of the restraint by a member of the public. You would try and manage that situation. So, they're different. Your response would be different, but you'd still be looking for the same things. You would take control of the situation, but you would do so very calmly. You're not going in with that authoritarian attitude, shouting. It's just: "Let's calm the situation down."

SBPI-00362: Statement of Inspector Young

91. I am referred to Paragraph 37 and 38, where it talks about two incidents where an ambulance did not attend where ABD was suspected. Although, from the passage, he cannot be certain whether the ambulance was refused by PS ACR or SAS ACC. It's difficult to talk to the specifics of these but, just generally on what's been said, if this call's gone from scene, I don't dispute the police officer on scene's asked this. That's a factual statement of what they've asked for, but if that call has then gone to a police control room and then been passed to us, we don't know what was said to the ambulance service, and that would influence the response that we provide. We may not have had the resource to attend. So, it wasn't that we were refusing; it's just that we didn't have the resource to send.

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92. I am asked if there is a scenario that I can anticipate in 2024 where an ambulance wouldn't attend a suspected ABD call. It would always be treated. My understanding of the additional guidance, we've got the police calls document (**SAS-00002**). The call would be escalated to a clinical advisor. We would be providing a response. Now, with the discussion, if you were able to talk to the police on the scene, you might be able to decide whether that's going to be a red response or maybe an amber response, or a time-critical one or whether we've got a bit longer, and that would be a joint assessment and decision between us and the police just as it is with any other patient, but ABD is going to create a high index of suspicion with any clinician.

93. I am asked whether in 2015 it would be possible that a suspected ABD wouldn't be treated as an emergency. Like we discussed, I suppose the term in 2015, ABD, there was a lot of different terminology that might not have been recognised. Again, we would respond on the symptoms that are described to us. If the question you're asking is: "Is our response better, potentially better now, as long as the protocols are followed more than it was in 2015?" – Yes, because we're in a better position now as a result of the evolving evidence for ABD.

94. That must have been an incredibly difficult situation for the police officers to have been in, but I think if we were given the date of the call and the time, we could review what happened.

Responders: 2024

95. I am asked whether SAS responders are trained to identify and treat ABD. SAS training, at present, doesn't specifically cover ABD, however it does provide advice that describes similar situations.

96. I am asked why our current training for responders doesn't specifically cover ABD. Our current clinical guidance provides advice on how to care for a patient presenting with ABD,

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highlighting it is a clinical emergency. SAS clinicians receive this guidance and updates via an electronic JRCALC App. ABD is not a formal diagnosis. It is the 'umbrella' term for the clinical presentation of a number of possible conditions. Additionally, we do provide all SAS staff with an underpinning knowledge to aid in the de-escalation process of aggressive individuals.

97. I am asked if ABD is covered in the JRCALC app for reference by paramedics, ambulance technicians and so on. Yeah, so that's what they would have in their pockets, and I guess that's the clinicians' bible. The JRCALC and the health and safety policy should align, so the JRCALC guidelines should be a practical description of what's in the health and safety policy and the current clinical guidance.

98. I am asked what treatments are available to SAS responders where ABD is suspected. So, as always, you treat the presenting symptoms. It's as described in the JRCALC guidance (**SAS-00007).** Obviously, scene safety, verbal de-escalation, provide restraint if safe to do so are all listed there. So, we don't restrain patients. I think in reality there's an element of pragmatism around that. You know, if somebody was going to walk out in front of a car and you were able to stop them and that was reasonable to do so, I think you would do it. You would gain IV access if it's safe although it's highly unlikely, as a single ambulance crew that you would be able to do that to somebody presenting with ABD. If the patient's got a reduced level of consciousness, you would do what you would normally do with a patient with a reduced level of consciousness. You would: position the patient on their side; provide restraint as required, for example a safety belt on a stretcher; give oxygen continually; and monitor the airway and breathing. Again, you would give oxygen if the saturation was below 94 per cent, and monitor the heart rate, blood pressure, capillary refill if you could.

99. If a patient presents with hyperthermia, you would try and cool the patient, remove clothing if possible, but sometimes you might not be able to. Again, the decision might be if something happens outside the hospital, on the hospital doorstep, it might be quicker just to get the patient into the emergency department, into resus, rather than spend time on

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scene, removing clothes. So you've got a more controlled environment, but if you could do so, you'd usually remove clothes.

100. If a patient presents with acidosis or hypovolemia, the likelihood of getting IV fluids into a patient displaying ABD is quite low. But IV fluids, they could be done by an SAS paramedic. We would do it if we could. We'd give them saline. Again, the decision would be taken: is it safer not to do this and take the patient to hospital, or will the patient benefit from this? And you need to make that dynamic decision on scene. You would ask: is it going to take you longer to secure IV access and start administering fluids than it would to take the patient to hospital? And if that's going to take you longer, you may just go straight to hospital without providing the treatment.

101. I am asked how an individual would have to be presenting to warrant rapid tranquilisation. That occurs where the patient was unmanageable. If they weren't able to be verbally de-escalated and if restraint wasn't working or restraint was potentially going to cause more harm.

102. I am asked what would happen were the patient to go into cardiac arrest; whether the background of potential ABD would still be considered or whether the priority is to perform CPR. You treat the cardiac arrest and, predominantly for paramedics, your treatment's the same every time but clearly that's important to know that the presenting condition was ABD.

103. In 2015, the crews were issued with two main reference books with them: the JRCALC pocketbook and an 800-page reference book. The reference book wouldn't have been carried in the ambulance; it's more of a textbook.

104. Now, all the information that would have been in the reference book is now available to them on the JRCALC app. So they wouldn't be flicking through the pocket book on scene.

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SAS-00009 - Advanced Practitioner Critical Care pocketbook

105. I am asked whether this pocketbook was in force at 2015. No, it was not. It's a relatively new creation and role. APCCs aren't the same as the critical care team, but but they'll work with them. Advanced Practitioner Critical Care - they'll be a mix of nurses or paramedics. They're nurses or paramedics with advanced skills in Critical Care. We have urgent care paramedics who have enhanced skills around urgent care, and then the medical teams, which are consultant-led, have an additional range of skills.

106. We have a Critical Care desk, and the Critical Care desk screen calls coming in. So, literally, one of their jobs is just to look at all the calls coming in and have an eyeball on incidents that may warrant the attendance of an APCC. Or a crew could request them. A dispatcher might notice, because a dispatcher will have an understanding on what's happening in their area, so they might see the type of call and know that there's an APCC nearby. The dispatcher might make the decision. There's a few different ways that they could be mobilised to a call.

107. I am asked if an APCC could be deployed to call where ABD is suspected. They would be deployed to ABD if they were available. They wouldn't generally be sent out without paramedics. They are generally an additional resource and they usually respond in a car. They're advanced practitioners; we call them "advanced practitioners clinical care" because then that covers the nurses and the paramedics.

108. I am asked whether there are specific treatment options that available to them that aren't available to regular paramedics and nurses. Yes - they can give a higher level of sedation.

SAS-00010 – Rapid tranquilisation

109. I am asked whether rapid tranquilisation was available as a treatment option for ABD as at 2015. No - the only way that would be from a medical team from a hospital.

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110. I am asked if I am aware of any data on the effectiveness of rapid tranquilisation in the management of ABD. I'm not familiar with the data, with the outcomes, but it's a recognised treatment. I am aware that in the RCEM best practice guidance Acute Behavioural Disturbance in Emergency Departments that the benefits of rapid tranquilisation are described and referenced to academic research by Kupas et al and Stormer et al , although I am not familiar with these individual studies. I also note that in the current JRCALC guidance that there is a lack of high-quality evidence in the medical literature to determine the most suitable single agent or combination of agents for rapid tranquilisation in the context of ABD. But certainly, the APCCs can give, as it was said in the response, sedation with midazolam, ketamine or haloperidol. So, paramedics don't give ketamine or haloperidol. It's an advanced practitioner medication. Then the medics can sedate the patient with full anaesthesia.

111. I am asked if doctors dispatched by SAS also have rapid tranquilisation at their disposal. In very broad terms, the doctors that respond for us will bring the resuscitation room to the roadside, where some of initial treatments provided in hospital would be delivered at the roadside.

SAS-00015 – Course on violence prevention, reduction and conflict management

112. A lot of the focus within this course seems to be on communication as a means to de-escalate a situation. I am asked whether the training in this course could and would be applied by SAS responders. Yes - the training in this course could be applied by SAS responding clinicians. I cannot categorically say that in all instances the training is applied but it is likely that it could be. However, communication is a key skill in clinical practice, and we know that unfortunately, clinicians regularly face situations that need to be, and are, successfully de-escalated using communication skills, without the need for support from the police or advanced clinical practice. So, I think it is reasonable to say the practice is widely, safely and regularly applied by responding clinicians.

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113. I am asked, from the perspective of a responder, how important I feel communication, verbal de-escalation is in pre-hospital care and management of suspected ABD. It's vital. It's absolutely vital. They just use those soft skills to de-escalate. There was evidence from London Ambulance Service which states:

> *"In a 2-year audit by the London Ambulance Service for cases where appropriately trained critical care paramedics responded to assess ABD, 62% of patients were managed using only verbal de-escalation followed by standard care."*
>
> So it's a very effective way of treating and managing ABD.

114. I am asked if there any circumstances in which SAS responders would not use verbal de-escalation to manage a case of suspected ABD. It's a step-wise process, and depending on the situation that you're presented with, that will guide at what point on the ladder you enter the process. We obviously have fewer options than police officers because we don't restrain. I think it's like I was saying earlier that clearly if somebody's going to walk out into traffic, and it's safe to do so, you would try and stop them doing that. You'd obviously try speaking to them first. It's a dynamic situation, and so I suppose the speed that you escalate up the steps will change given the situation.

115. Sometimes you could spend a very, very long time on step 1, to try and calm things down, and the situation will still escalate. Other times it might get to a rapidly evolving situation where actually the time spent on step 1 is minimal.

SBPI-00697 – Consensus on Acute Behavioural Disturbance in the UK (CABDUK)

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116. I am referred to the above noted study, the aim of which is to encourage and support a multi-agency approach to the management and treatment of ABD in the UK. One of the stakeholders in this study is the Association of Ambulance Chief Executives ('AACE') of which SAS are an associate member. I am asked whether I see a benefit to the proposal noted in this study. I wasn't familiar with this paper until I saw it yesterday but, absolutely, multi-agency collaboration is always the way that we get the best outcomes, and it's something that we do across a wide range of areas.

117. I am asked whether I am aware whether SAS have partnered with other emergency services on ABD training. I'm not aware of anything specifically with the police or the fire service around ABD. With the Scottish Prison Service, we did develop some joint guidance around managing ABD. That draft guidance was approved in 2018, but then JRCALC published their guidance. We actually sent our guidance to JRCALC, so we've not done any further direct collaboration with the Scottish Prison Service. But that's just for transparency, that although not an emergency service, that we did have conversations and collaborate with the prison service, and we did draw up the guidance, and they also discussed their restraint processes with us.

118. I am asked whether the SAS would be interested in trying to create a more collaborative approach with Police Scotland on ABD specifically. Yes, absolutely, and we currently have established links with both Police Scotland and their clinical governance committee and Scottish Fire and Rescue Service with their clinical governance framework, but to the best of my knowledge we don't have any specifically around ABD.

Protocols across health boards

119. I am asked if the SAS have to adhere to health board standards and guidelines on ABD. The response from the hospitals is all aligned to the major trauma network, you know, and it's those trauma centres, broadly speaking, in those areas that we would have the option to request a trauma team. However, as we have discussed, the SAS broadly

work to the content of the JRCALC guidelines. There is already some alignment of guidance used within pre-hospital response in Scotland. For example, BASICS Scotland have access to the SAS and JRCALC clinical guidelines. BASICS Scotland is a voluntary charity with doctors, nurses and paramedics who take an interest in pre-hospital care. On some occasions, mainly in rural areas, the SAS will ask BASIC responders to attend incidents alongside SAS crews

Professional membership: Accountability of SAS

120. I am firstly asked what it means to be an associate member of AACE and whether being a member constitutes a duty to adopt their guidance into our own. We contribute to AACE. It's maybe easier to answer this more broadly. With all guidance, it's up to the service whether they adopt it or not. The JRCALC clinical guidelines, are published. It's then the organisation's decision – so it's SAS's decision – whether we implement them or not. We review them and then implement them and sometimes we'll make changes to them to meet the unique needs of Scotland. AACE aren't a regulatory body.

121. As healthcare professionals, its implicit that we use the latest guidance. From a clinical perspective, we have a clinical governance framework, and the medical director sits at the top of the clinical governance framework, and it's our responsibility as an organisation to be using the latest best practice.

122. The ambulance services are actually quite uniquely placed. There's not really another professional body that has a set of guidelines like JRCALC. JRCALC is the Joint Royal Ambulance Liaison Committee (sic). So, they represent all the royal colleges and medical colleges in the UK. They all get together and agree what clinical guidance ambulance services should be using. Now, I think every UK ambulance service uses JRCALC because it's a central point of excellence. They have a sort of iterative process to review the guidelines and a whole governance structure around that. They issue updates about four times a year. We review them. We very, very rarely don't adopt a guideline. What we

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will do is we'll sometimes put a Scottish context on it, just because of the way we deliver care within Scotland. It would be unusual for our service not to use JRCALC. Our clinicians aren't looking at lots of different manuals. For example,they don't have to be looking at NICE and SIGN. There are not lots of different sources of clinical guidance. I mean, JRCALC is the really considered the bible for our guidelines. What JRCALC does is JRCALC pulls all that information together and consolidates it in a single source.

123. In terms of accountability as an organisation, we're responsible for this to Scottish Government and through our internal governance systems and the professional bodies we're individually regulated by as clinicians.

124. Individually, as a paramedic, my professional body is the HCPC. For nurses, it will be the NMC, for doctors, the GMC. That's their professional bodies, and they have to meet the requirements of those professional bodies. But we're employed by the Scottish Ambulance Service. Our practice guidelines are approved by the Scottish Ambulance Service, my employer.

Contact with other witnesses

125. I am asked if I have been in contact with other witnesses. Yes, I have been in contact with Isobel Donaldson, Learning and Development Manager for the East Ambulance Control Centre. This was to identify and source some of the guidance we have supplied to the inquiry. Isobel also provided a peer reviewed, for accuracy, the parts of my previous written responses (the position statement response) relating to ambulance control room procedures.

Involvement with the investigations

126. I did provide some guidelines to the legal office. I think it was through a Freedom of Information request. I've never been involved in any review of the incident itself, but in 2019 there was a request for some guidelines.

127. I've not been following it closely. I've seen what's reported on BBC, because there's obviously a professional interest, and I have accessed some of the information on the public-facing website. I accessed some of the information on police training, and that was actually in trying to provide a response to yourselves, so I watched a couple of the videos with police training. I watched a couple of the witness statements, but I haven't been watching it closely.

Declaration

129. I can confirm that this statement is true and accurate to the best of my knowledge.

October 22, 2024 | 4:07 PM BST
Date .....

Signature of witness .....