The Sheku Bayoh Public Inquiry

Witness Statement

Isobel Donaldson

Taken by [redacted] **3rd October 2024**

Background information

1. My name is Isobel Donaldson and my date of birth is [redacted] 1960.
2. I have been in my current role as Learning and Development Manager within the Ambulance Control Centre for about 8 years.
3. I joined the Scottish Ambulance Service in May 1996. I joined patient transport services as an ambulance care assistant. I was based initially in Glenrothes. Then in 1998, I became a technician and was based in St Andrew's station, before I moved down to Kirkcaldy station about six weeks later.

Signature of witness . [redacted] ……..

4. I became a paramedic in 2002. I remained working in Kirkcaldy Station. I think it was 2009 I went into the ambulance control room as a clinical advisor. I was initially only meant to stay for 6 months, but I stayed and became the clinical supervisor there, then clinical manager. I've had various titles since then, but essentially I stayed in that role, becoming clinical support and quality manager. I stayed in that role until I joined my current role in 2016. I've been in my current role as the Training and Development Manager since then.
5. My role as Training and Development Manager within the ACC gives me knowledge and expertise in MPDS. I don't have oversight of the clinicians within the ACC and I haven't worked within the Clinical Hub within the ACC for some years. In relation to questions about clinicians and the Clinical Hub, I'll give my answers to the best of my ability and knowledge.

Ambulance Control Centre: MPDS and MTS

6. MPDS is a triage system for call handlers and call handlers alone, so it's designed for non-clinical staff or staff with a non-clinical background. MPDS is the first system that would be used when a call arrives at the Ambulance Control Centre ('ACC').
7. The use of MPDS within the ACC has not changed since 2015.
8. I am asked how MPDS is set up and whether it is set up to determine a specific diagnosis. I am further asked whether MPDS functions in the same way in 2024. It's still the same. We do have some real exceptions to that, but there are only a

Signature of witness ….. [redacted] ……..

few really specific life-threatening conditions that they've added to that. Only those would be set up to determine a specific diagnosis.

9. Generally speaking, if we make a good case, the Academy will add another descriptor, or they can add another code in. They can absolutely do that. We just need to evidence that it's necessary. The system is also a worldwide system, so when it gets added, it gets added worldwide. There is also the recognition that it might be specific to the UK, but actually the system itself is going out to the wider world.
10. I am asked what happens when the call handler produces a code and where that code goes after. The code is almost a summary of the information that we've been provided with and that code then goes to our dispatchers. The code itself has had an acuity level assigned to it already and the call handlers have no influence over that and the outcome whatsoever.
11. For those low acuity calls that come out as green, for example, there might be an instruction to the call handlers to refer it to the clinical support desk rather than dispatch. It indicates that it needs some clinical input rather than an ambulance. Otherwise, the code itself goes to our dispatchers and then based on the acuity level, they have a predetermined attendance that goes along with that, they look at what resources are necessary to attend that patient and then they look to see what vehicles they have available. They ask: do they have the right skill set, et cetera.? Then they deploy those vehicles accordingly.

Signature of witness ….. [redacted] ……..

12. MPDS call handlers do have some post-dispatch instructions that they can give. Those instructions are on the protocol themselves and those are generic instructions, like opening the door, putting away the pets and turning on lights and stuff like that. It might be if the patient is unconscious, for example, they give instructions to put them on their back, manage their airway, check their breathing so they have instructions for all of those. They have instructions for childbirth. We can help deliver babies. They have instructions for choking patients. So in that immediately life-threatening moment, they have a variety of instructions that they can use as well as administering or helping the caller administer drugs such as epinephrine and naloxone. Again, in those real dire emergency situations where they need to administer medications at that moment, the instructions are scripted and they need to be read word for word. There are quite a few that they have there.
13. I am asked if there are any specific instructions for ABD. There are no specific instructions for ABD. Call handlers are trained to manage symptoms not to make a diagnosis. They look first of all for immediately life threatening symptoms and once ruled out, use the other presenting symptoms to determine an appropriate protocol to use and assign an appropriate code. Any instructions would be dependant on the patient's condition.
14. MTS is the secondary triage tool that's used by clinicians within the ACC. Once the call handlers have done the initial triage, and they've coded the call using MPDS, then it sits waiting on an ambulance, and then the clinicians will have a look at it.

Signature of witness ….[redacted]……..

Some of them have been designated as low acuity and suitable for further triage by a clinician. Those are the ones that would be specifically picked up by them.

15. I am asked whether calls would be referred for further clinical assessment where they are deemed too complex. Yes, that can also be the case. There are a variety of different calls received by clinical advisors within the ACC, ranging from low to high acuity cases.
16. The use of MTS has not changed since 2015. It's still used in exactly the same way. However, there have been upgrades to the system and changes in MTS with new versions.
17. Similarly with MPDS, it is still used in the same way, but there will be some calls now that will be referred to the clinicians that weren't perhaps in 2015. The principle remains the same; there might just be some more codes.
18. I am asked to confirm which specific protocol would likely be used where ABD is suspected. I am asked to confirm whether it would be the appropriate protocols would be those provided in **SAS-00012**, **SAS-00013** and **SAS-00014**, which contain Protocol 9 and 32 (2013 and 2015 versions) and Protocol 9 and 33 (2023). I can confirm that to the best of my knowledge, these would be the most appropriate protocols for patients with ABD.
19. I am asked why there is not a specific protocol for ABD. Sorry, I don't know.
20. I am referred specifically to **SAS-00014,** which is the latest version of MTS – Protocol 9 and Protocol 33 (in previous versions, 9 and 32). I am asked whether the addition of the ABD red warning box within that those Protocols reflects that

Signature of witness … [redacted] ……..

MTS now recognises that ABD should ring a red flag in the clinicians' minds. I can't comment on the rationale for changes in MTS but am aware that there was a bit about ABD added at the bottom, and if I remember correctly, it does say that these are the symptoms they could be presented with by the police and to refer it to a clinician for review, if that was the case.

21. I am asked how a case of suspected case of ABD would be processed by a clinician within the ACC. I can only talk about how it was in the past, and obviously things have changed, but I don't think the principle has changed. MTS is a bit like MPDS, it is a reductive triage process meaning that all patients start with the highest priority with life threatening and serious conditions excluded first. The presenting complaint allows an appropriate card to be selected for use during triage. It serves as much as a reminder for clinicians as anything else when you're processing a call, or when you're reviewing or speaking to someone on the phone.
22. MTS is almost reminding you. Have you thought about, have you considered? Then you look down the list and see I've done that, I've asked that, but I'm happy with that bit. Then you come to a descriptor, a bit like MPDS, you come to a point where you think, right, OK, I can stop there because that bit applies. That gives you the outcome code, then what you'd expect to do with that patient. I would suggest the ABD bit was added as a reminder for clinicians to look for those symptoms specifically and then to do something with it when they do find it.
23. The point in that red box being added is more something to consider that if you see this group of symptoms, think of ABD as a possibility. That group of symptoms can

Signature of witness ….[redacted]……..

also be attributed to a number of other medical conditions; it's why our call handlers aren't left to make the decision that that is the cause, because it might not be. It could be something else. That's for the clinicians to determine whether that ABD is the cause or if there's something else going on that they should be aware of.

24. I am asked whether clinicians would make a diagnosis, or whether they would wait until paramedics are on scene before it is confirmed. They would almost have to make the decision at that point because that will determine the acuity of the call. If they triage a call and they determine that the symptoms look like ABD, then you would have to upgrade the call to a higher acuity level and then it's almost academic what the clinicians find at that point because even if they're wrong, they've done it for the right reasons based on the information available at that time. They've got a resource there faster than they would have done otherwise.

25. I am asked what information and advice that a clinician can provide that a call handler cannot. That would be your self-care advice; either to take yourself to a minor injuries unit, you need to phone your GP etc. Or if it's more appropriate than an ambulance response, we would just give some self-care advice to take some medication or give them some advice on how to manage their condition at home without having to speak to anyone else.

26. I am asked if the call is treated differently where it comes directly from scene versus through the ACR to ACC. Yes it is now. Where the call is received from the police officer on scene, the officer would be asked the same questions as a member of the public so that accurate information on the condition of the patient is received. This

Signature of witness … [redacted] ……..

allows an appropriate acuity level and response to be assigned. If however, the call is received from the ACR, then the SEND protocol is used. This is an abridged version of the protocol questions which recognises that the caller is not with the patient and therefore is only able to give the information that was passed to them. The main information required is around any scene safety issues that may pose a risk to our responders or the patient and any information that would suggest the patient is in an immediately life threatening condition. Back in 2015 we would only have used the SEND protocol as all calls were received via the ACR and not from scene.

ACC: Call handlers – ABD - 2015 and 2024

27. I am asked about the qualifications of call handlers within the ACC as at 2015. The qualification itself is the same as it is now. MPDS itself is licensed by the International Academy of Emergency Dispatch. As part of the license, call handlers have to be certified to take calls and to use the system.
28. Back in 2015, they were trained our IT team who were non-clinicians but that has since changed.
29. In around 2016, the Academy made the decision that the instructors had to be clinicians. That was the reason that I became an instructor.
30. The call handlers are not clinicians. It's a non-clinical triage system. The call handlers are not expected to be able to diagnose patients.
31. I am asked whether ACC call handlers are now trained to recognise the signs and symptoms of ABD. So, again, not specifically ABD because the signs and

Signature of witness . [redacted] ……..

symptoms can be attributed to other medical conditions and the call handlers are unable to determine whether ABD is the cause. We provide guidance within our bulletins on how to manage calls received from the police where ABD is given as a suspected diagnosis. We don't specifically train for ABD as a clinical condition.

32. I am asked if there have been any specific bulletins or newsletters which raise awareness of ABD that call handlers would have access to. To my knowledge, the most recent one was the police calls from scene bulletin that went out with ABD mentioned in that. But other than that, I can't think of anything off the top of my head.

33. I am asked how call handlers would process a call where the patient was reported to be suffering from suspected ABD. In terms of MPDS, the thing to bear in mind is that it's a non-clinical system. The algorithm itself is designed to rule out any immediately life-threatening conditions. For those life-threatening conditions, the call handlers are trained to give some life-saving instructions to assist their callers. They start by ruling out symptoms of immediate concern such as unconsciousness, difficulty breathing, chest pain or significant haemorrhage and once they're happy that the patient is not presenting with any of those, they then look at the rest of the symptoms. They select a protocol, answer the questions and that gives them a code. Then the call handlers give any appropriate instructions to manage the patient until the crew arrives. The interpretation of those symptoms is for the clinicians. It's not for our call handlers to do so.

Signature of witness ……[redacted]……..

34. In terms of ABD specifically, back in 2015 as now, we would be looking at the symptoms that they present with. We would be looking at the agitation, the abnormal behaviour, the delirium. If they did exhibit any life-threatening symptoms, so if they did exhibit breathing difficulties, difficulties from hypoxia; anything like that, that would be a different protocol. If they came on and said they were having difficulty breathing, then they would go down a different protocol for that. But for the behaviour side of things, it would be Protocol 25 because they're not behaving as we would expect them to behave. That stands today. We've added more questions into 25, but the principle remains.

35. I am asked why there is not a specific protocol for ABD. This is a supposition on my part however, from the Academy perspective, because it's a non-clinician working in a non-visual environment, we rely very much on the callers to give us the information we need to make an assessment on the condition of the patient. Once we start putting in specific conditions then we're expecting our call handlers to diagnose patients, to make an assessment as to what the clinical outcome of that call would be, when actually that's not their role, and it's not what they're trained to do, nor do they have the skill or the knowledge to be able to do that. The Academy deliberately, with a few exceptions, doesn't put in specific clinical diagnoses.

Hypothetical response to ABD: 2015

Signature of witness ……..

36. I am asked to consider the call handler's response had Sheku's behaviour and demeanour been reported without mention of ABD. I am told that the Inquiry has heard evidence that Sheku was unresponsive to verbal commands and to the deployment of CS/PAVA spray, and that he was reported to be wielding a knife and striking out at vehicles with that knife. They would have gone with the symptoms that were exhibited. If he wasn't responsive, they could have gone with a reduced level of consciousness protocol. Or with the wielding the knife and threatening people, they could have gone with the abnormal behaviour protocol. So again, depending on how that was relayed, some or all of the information would be used to select an appropriate protocol but we can only manage what we know.
37. Occasionally, when crews get there, they get a different picture because that wasn't what the call handler was told or they think: "We were told the patient was more alert" or able to do things that they actually aren't in reality when the crews get there. It very much depends on the picture that they give us. In that scenario, I would suggest they would use the reduced level of consciousness part and potentially the abnormal behaviour part.
38. I am asked what the outcome would be if the call handler used the reduced level of consciousness or abnormal behaviour protocol.

MPDS: Protocol 25 – journey of a call

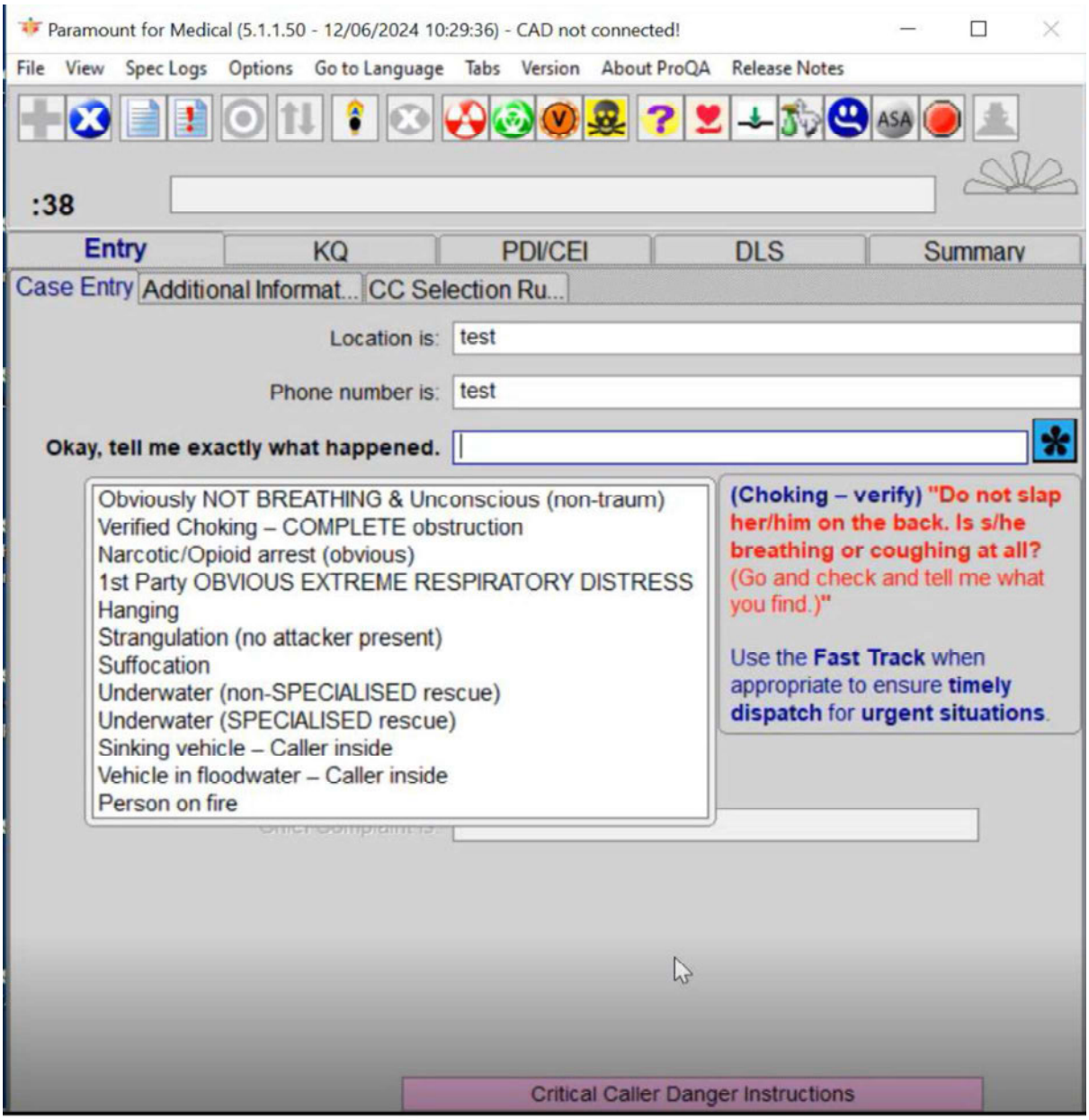
39. The system that I am showing you is ProQA in a standalone mode, which is a test mode so that I can show you how it works. The call handlers are able to use the

Signature of witness …… [redacted] ……..

system in standalone mode as part of our business continuity if we need to switch off the system for example to do an upgrade. ProQA works in conjunction with the computer system. I am showing Protocol 25 because if a call is received as an emergency from a member of the public, it is highly likely that a case of suspected ABD would be handled using this Protocol.

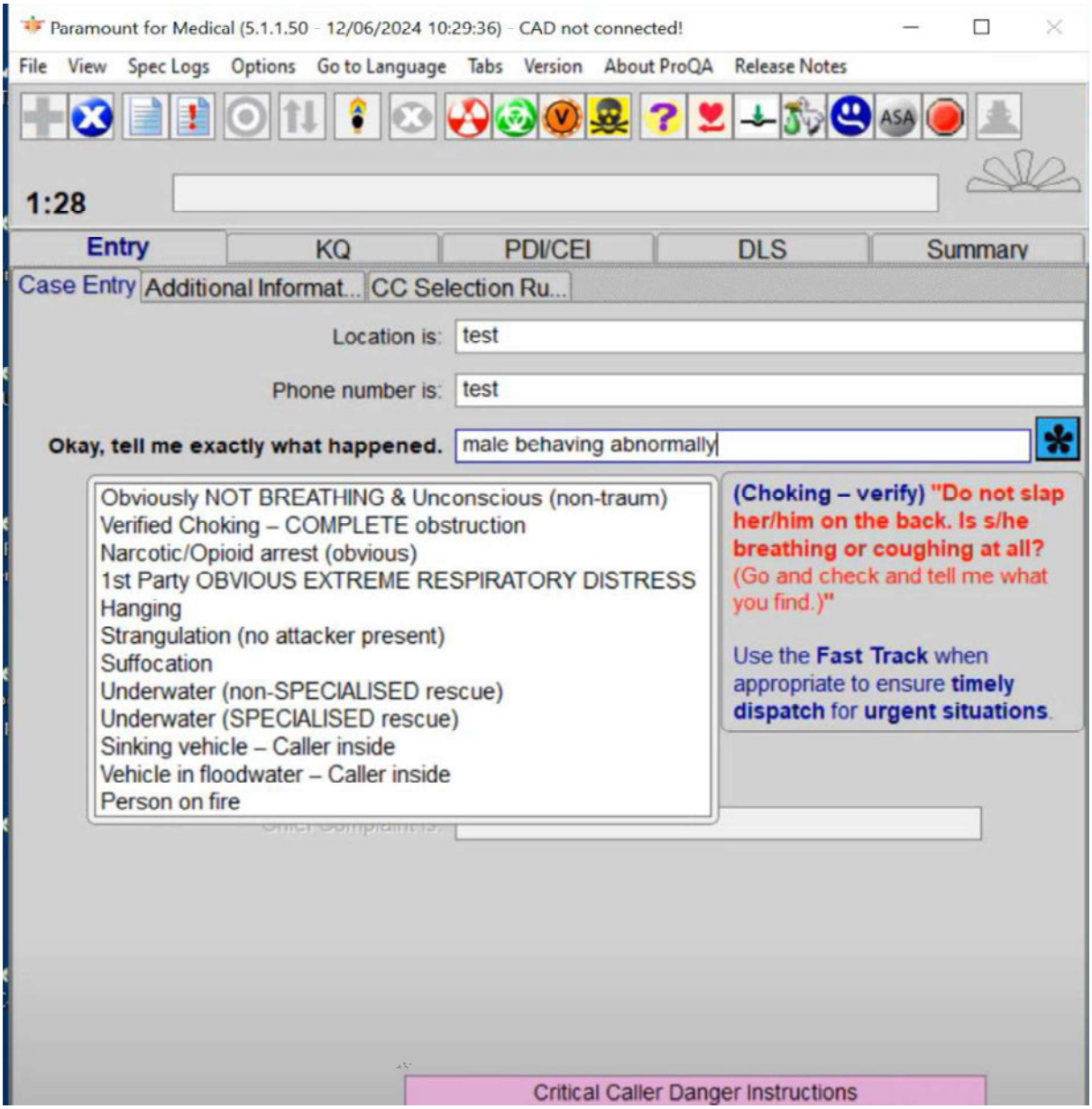
40. This first screenshot shows where the address and the phone number would automatically populate from the system. Then we would ask the caller: "Tell me exactly what's happened." And that's when we would expect them to come back to us with a description of what's going on at the time.

Signature of witness ……[redacted]……..



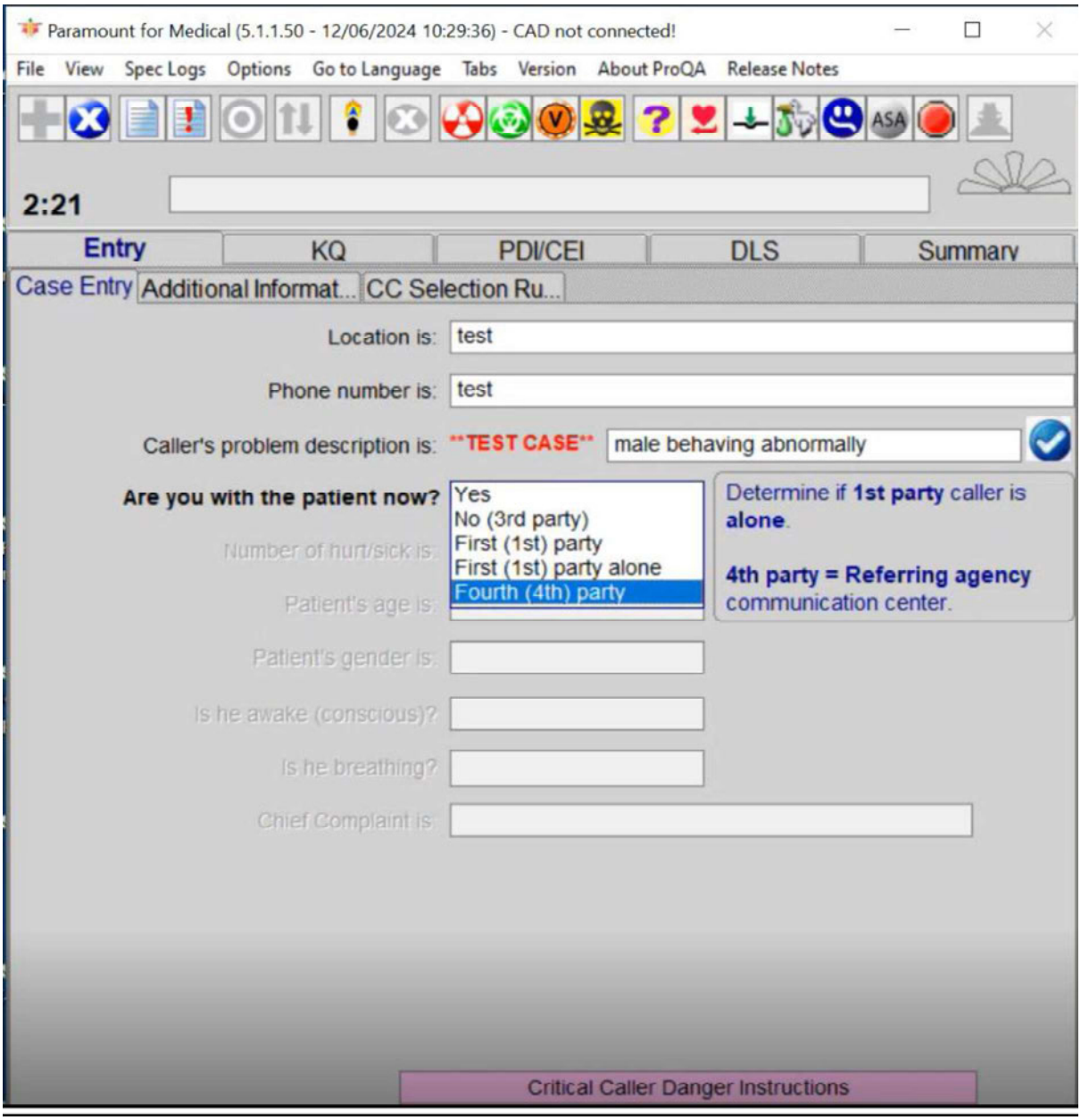
41. I am asked to consider the witness accounts from the day, before Sheku went into respiratory arrest. I have concluded that the first selection would be that the patient is 'behaving abnormally'.

Signature of witness …… [redacted] …..



42. If the call came through from the police control room, it would be classed as a fourth party call. The first question you would ask is: "How many people are hurt?".

Signature of witness ……[redacted]……..

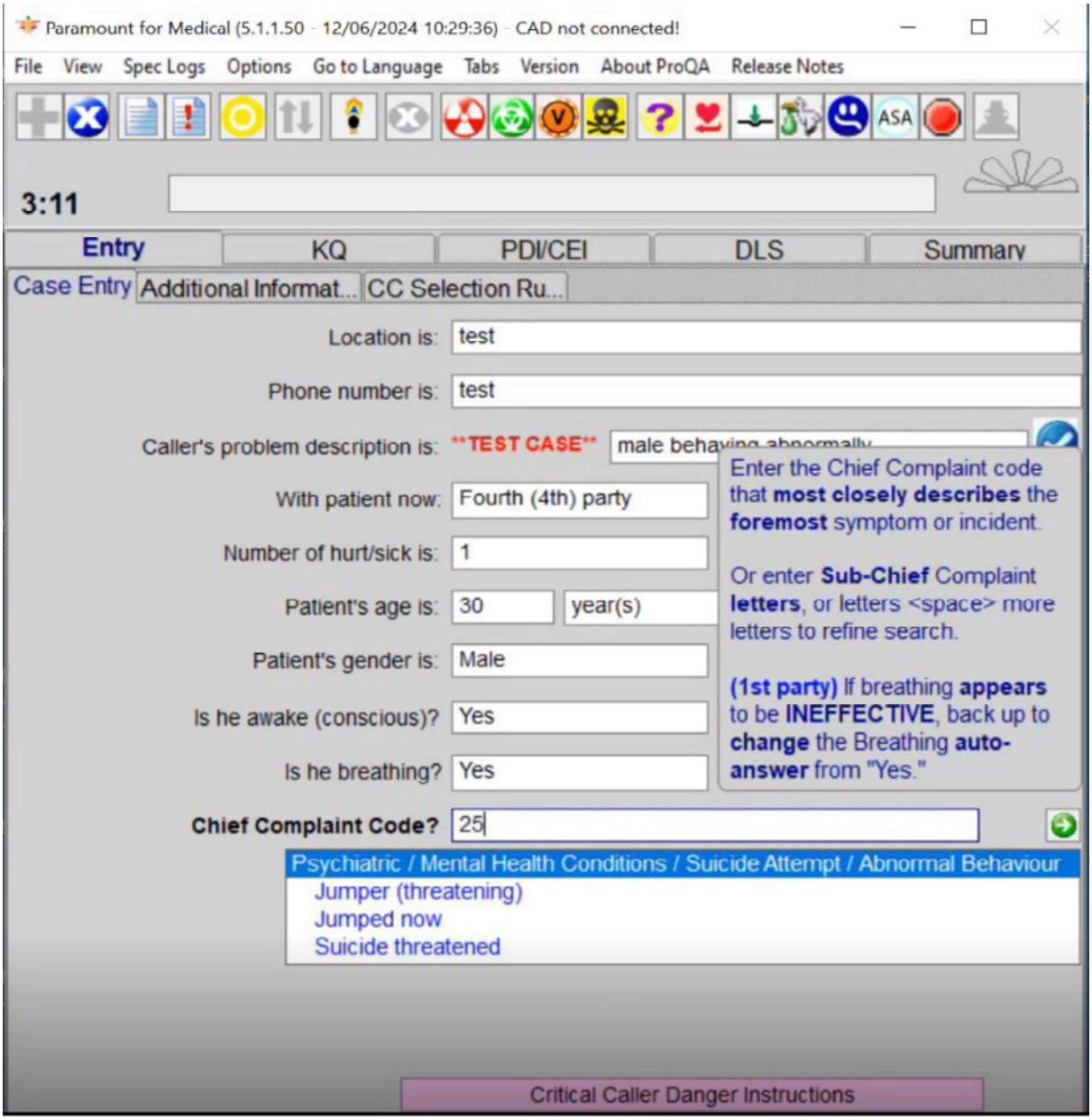


43. Then you would ask how old the patient is, if they can give us an exact age, you would put in an approximate age. The distinction with that is: "Is that an adult or a

Signature of witness ….. [redacted] ……..

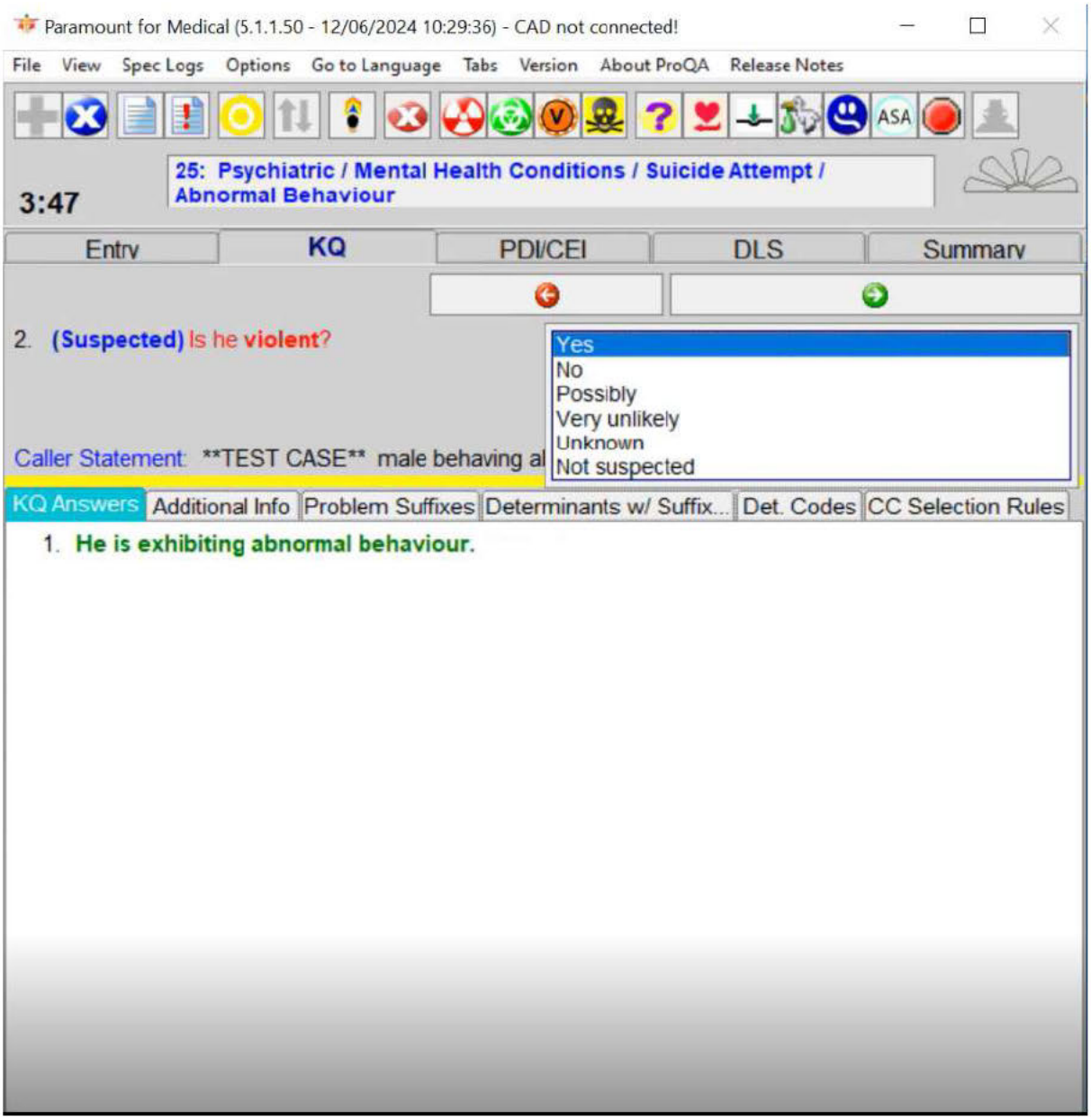
child?" really, because that affects the instructions that we give later on down the line. Then you'd input 'male', then 'awake', and then 'breathing'. Then we are going to put '25' because we know that it's potentially a mental health condition. Finally, we would ask: "What type of incident is it?" Obviously, you can see there's a whole list of things that they can choose from but the bit we're thinking about is the abnormal behaviour. Now, they could go with, you know, "Using a weapon" but they're not threatening to harm themselves in any way at the moment, so it's abnormal behaviour currently, which is what they would select.

Signature of witness ….[redacted]……..

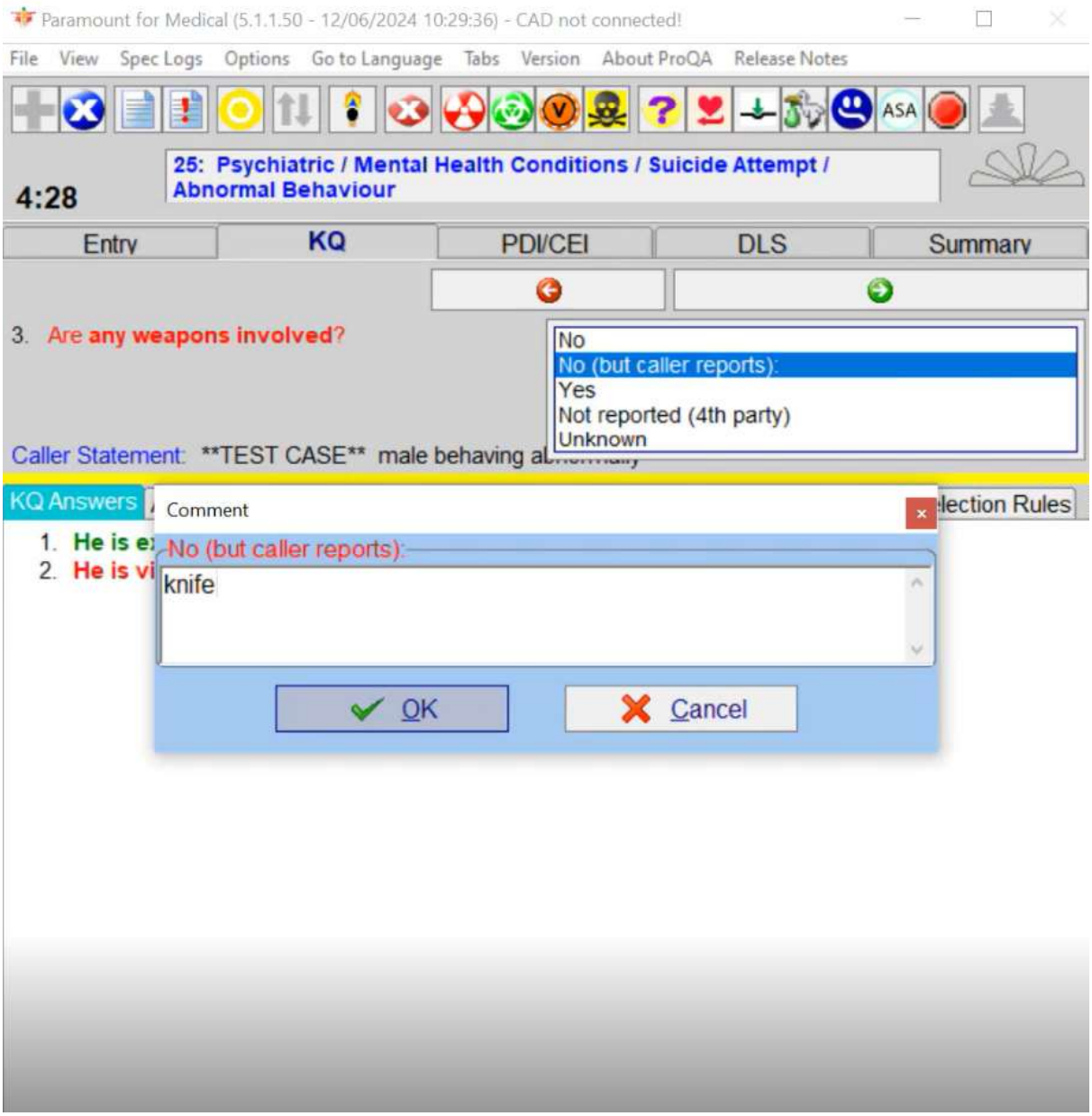


44. Then the call handler would ask: "Is he violent?". Given the fact that they're restraining him, that would suggest yes. "Were there any weapons involved?" We could say no here, but the caller reported a knife possible, so you would just put 'a knife' in there.

Signature of witness …… [redacted] ……..



Signature of witness …… [redacted] ……..

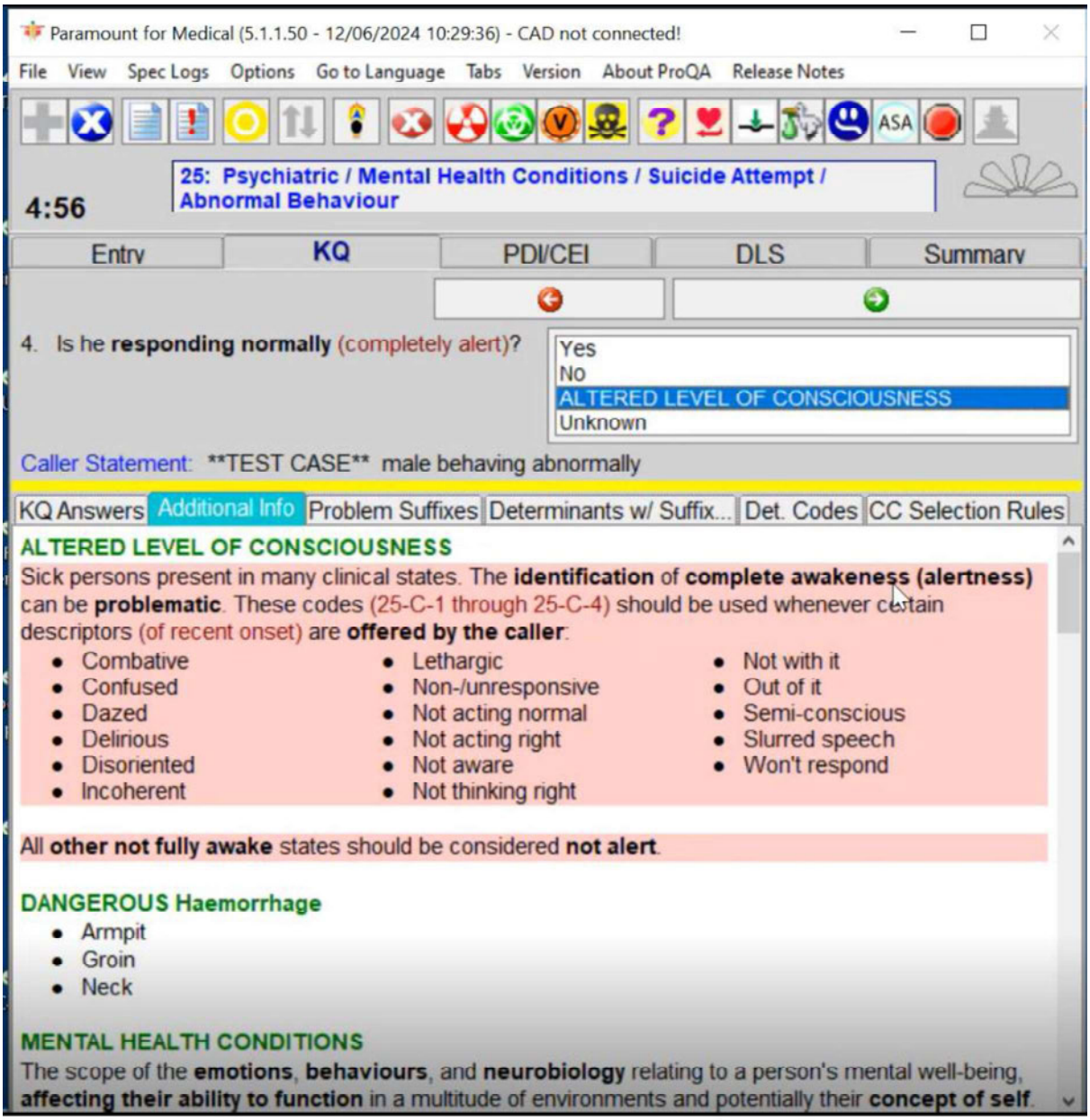


45. Then we would ask: "Is he responding normally?" So, this where we said: "No, he wasn't responding normally," because he was very combative and not acting normally, so we could use the altered level of consciousness

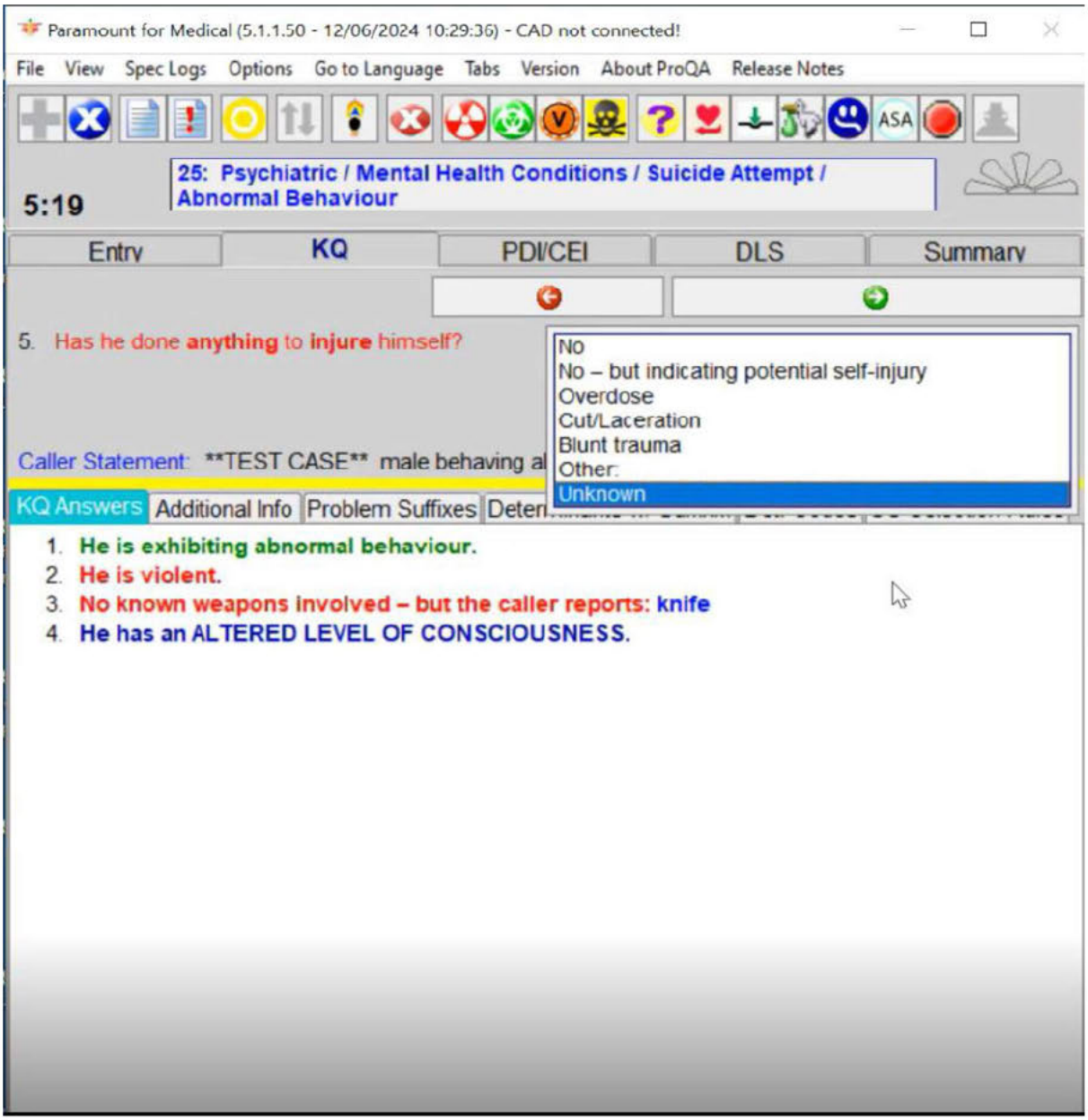
Signature of witness ..... [redacted] .....

descriptor which would say either: “No, he wasn't responding normally,” or “He's got an altered level of consciousness,” which is what we're suspecting here, because of the descriptors that we're given. You could use either; the outcome would be the same. Then: “Has he done anything to injure himself?” We could answer unknown to that unless we’re told otherwise by the caller.

Signature of witness …. [redacted] ……..



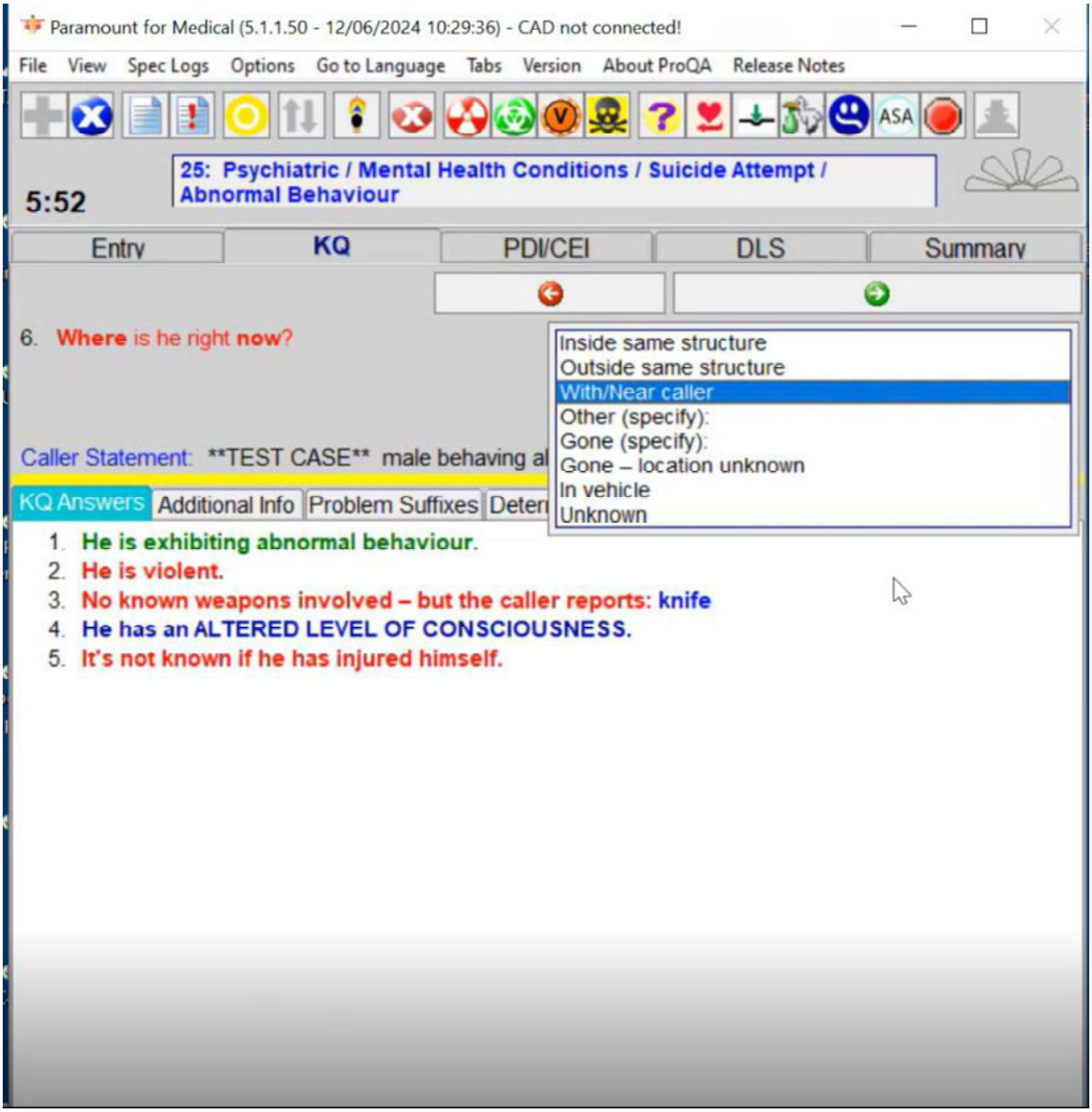
Signature of witness … [redacted] ……..



46. I should mention that all of these questions in red are scene safety questions. These are questions that we would have to ask the police. This would have been slightly different from 2015 because we've got a lot more questions now than we had then.

Signature of witness .. [redacted] .....

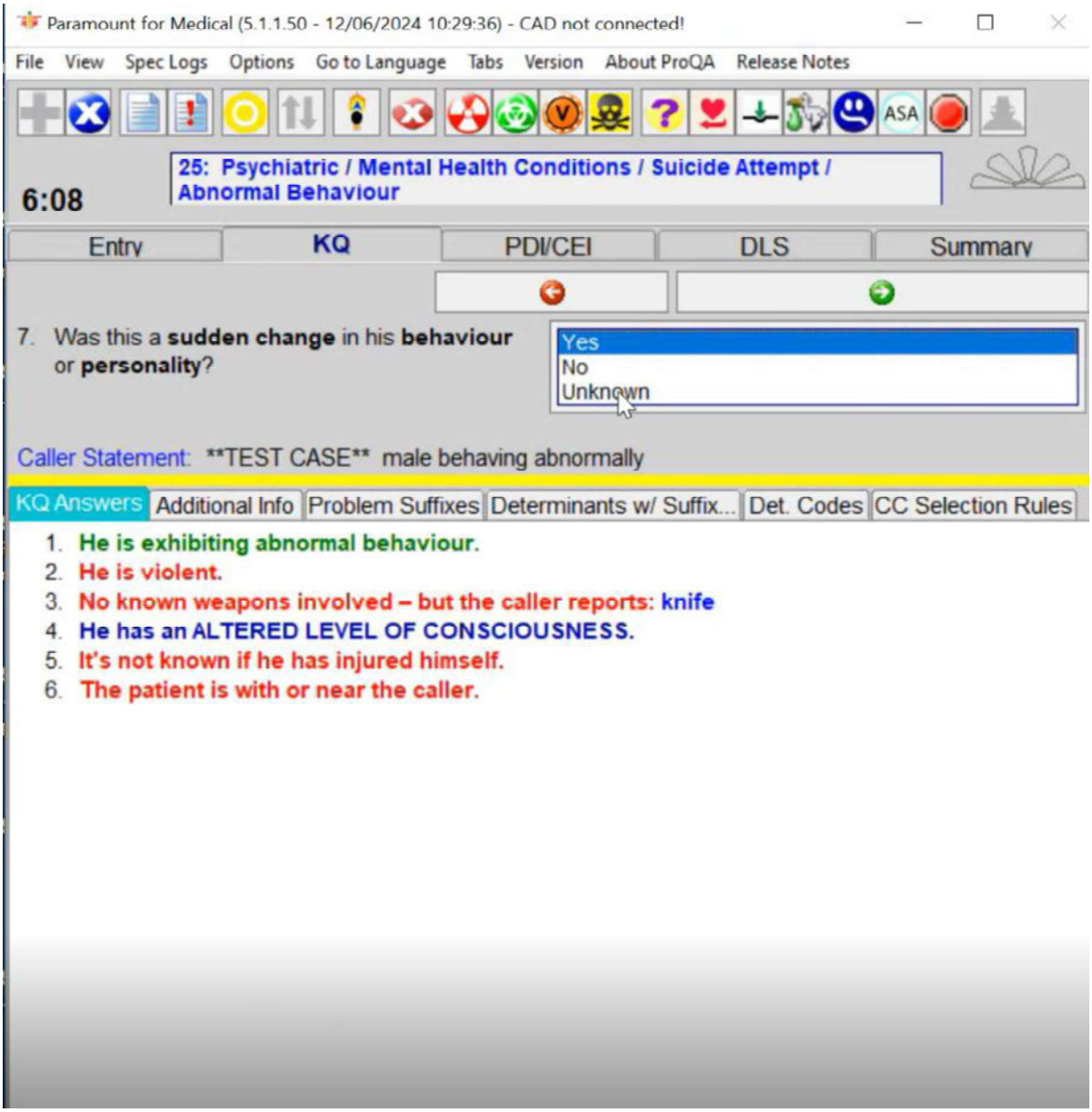
47. We would then answer that the patient is near the caller as is the case in this scenario.



48. The call handler will then ask whether the there was a sudden change in behaviour.

Signature of witness .. [redacted] ……..

Signature of witness ……  ……..

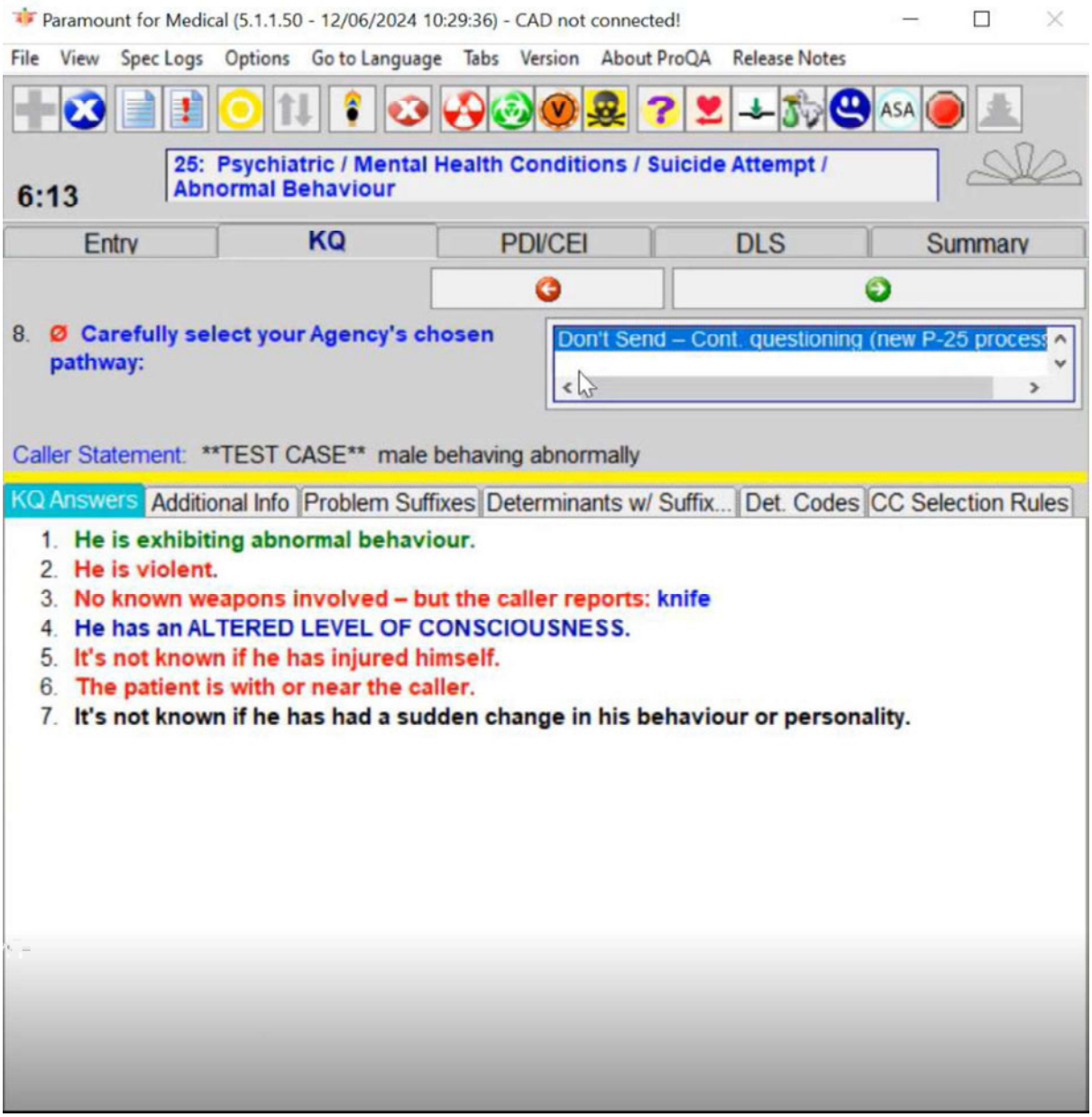


Signature of witness .. [redacted] ……..

49. The call handler will need to decide which pathway to use; either to continue with questioning or to select the code at that point. As a service, SAS have advised

Signature of witness …… [redacted] ……..

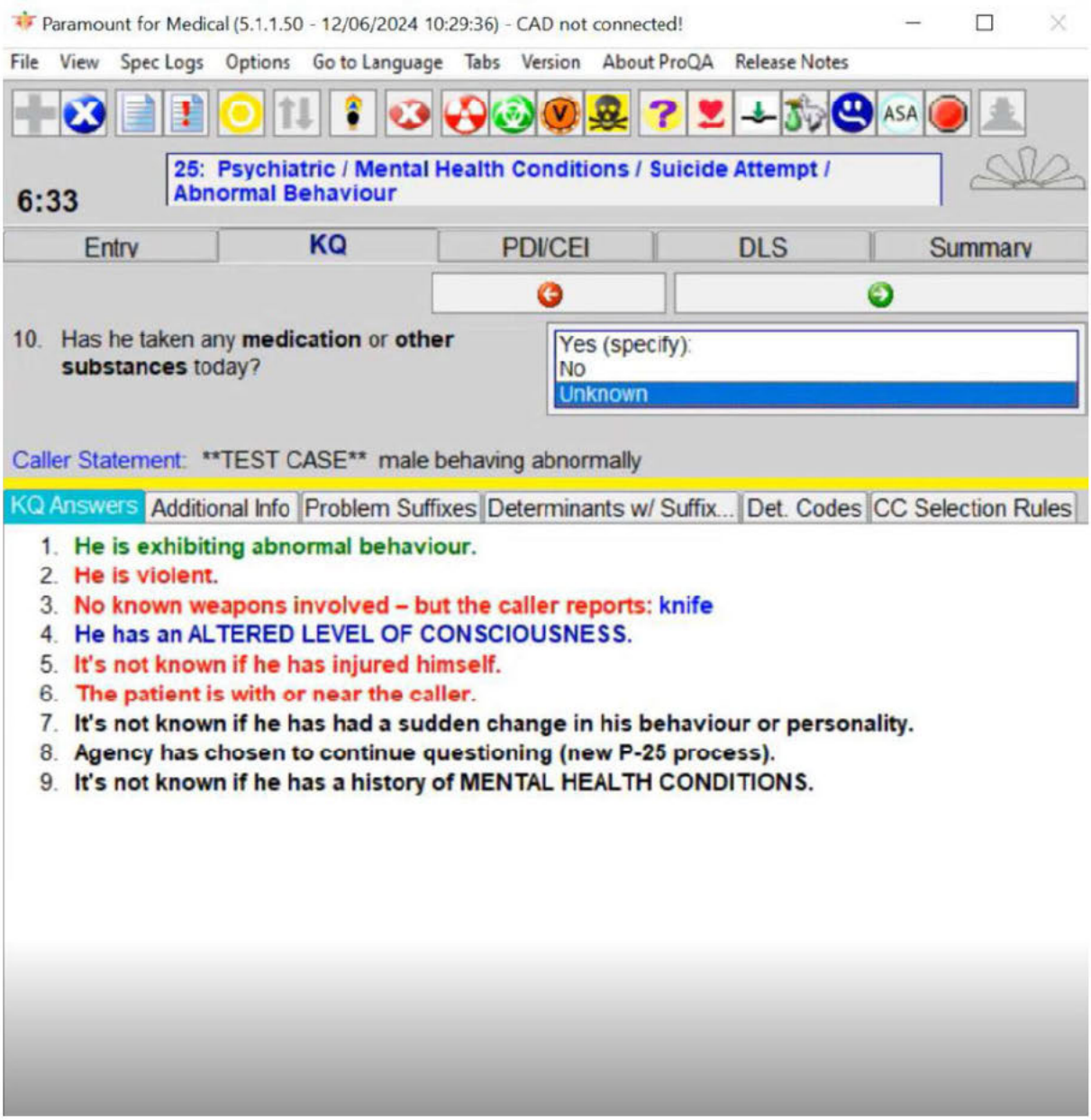
that the 'don't send and continue questioning' pathway should always be used.



50. The next questions concern medication or other substances. The police control room wouldn't necessarily have that information unless it has been passed from the police at scene. Generally, we wouldn't ask that question and instead

Signature of witness … [redacted] ……..

'unknown' would be selected.

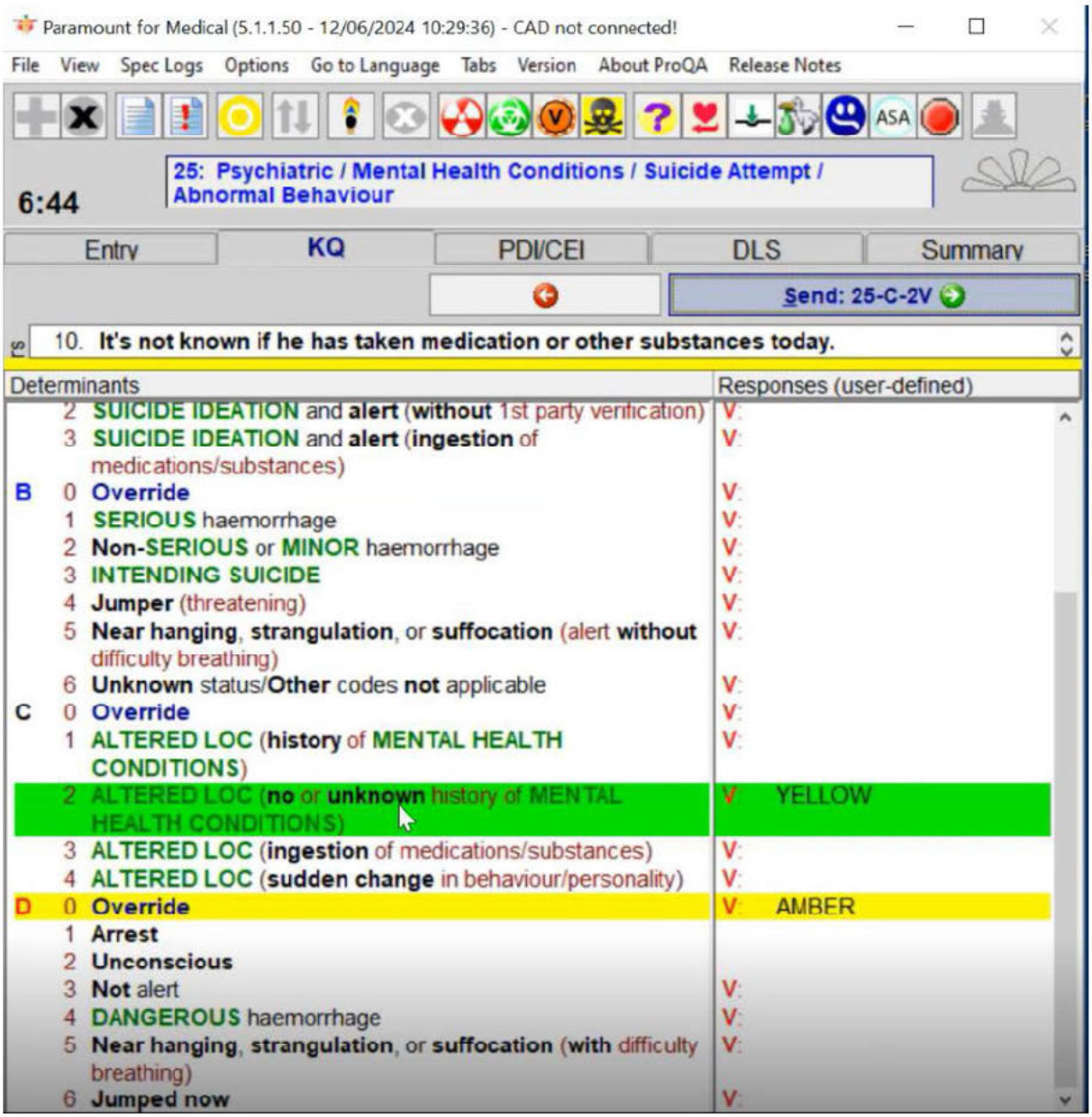


51. The below screen shows the final code based on the answers to the questions as 'Altered LOC (no or unknown history of mental health conditions)'. This gives a pre-determined acuity level of yellow, and this is the code that is sent to dispatch. Within

Signature of witness . [redacted] .....

the system there are 6 acuity levels ranging from purple, red, amber, yellow, green and teal. The highest level of acuity is purple for those patients whose condition is immediately life threatening and who require an immediate response down to the lowest acuity of green or teal who require further assessment but not necessarily an ambulance response.

Signature of witness .. [redacted] ……..



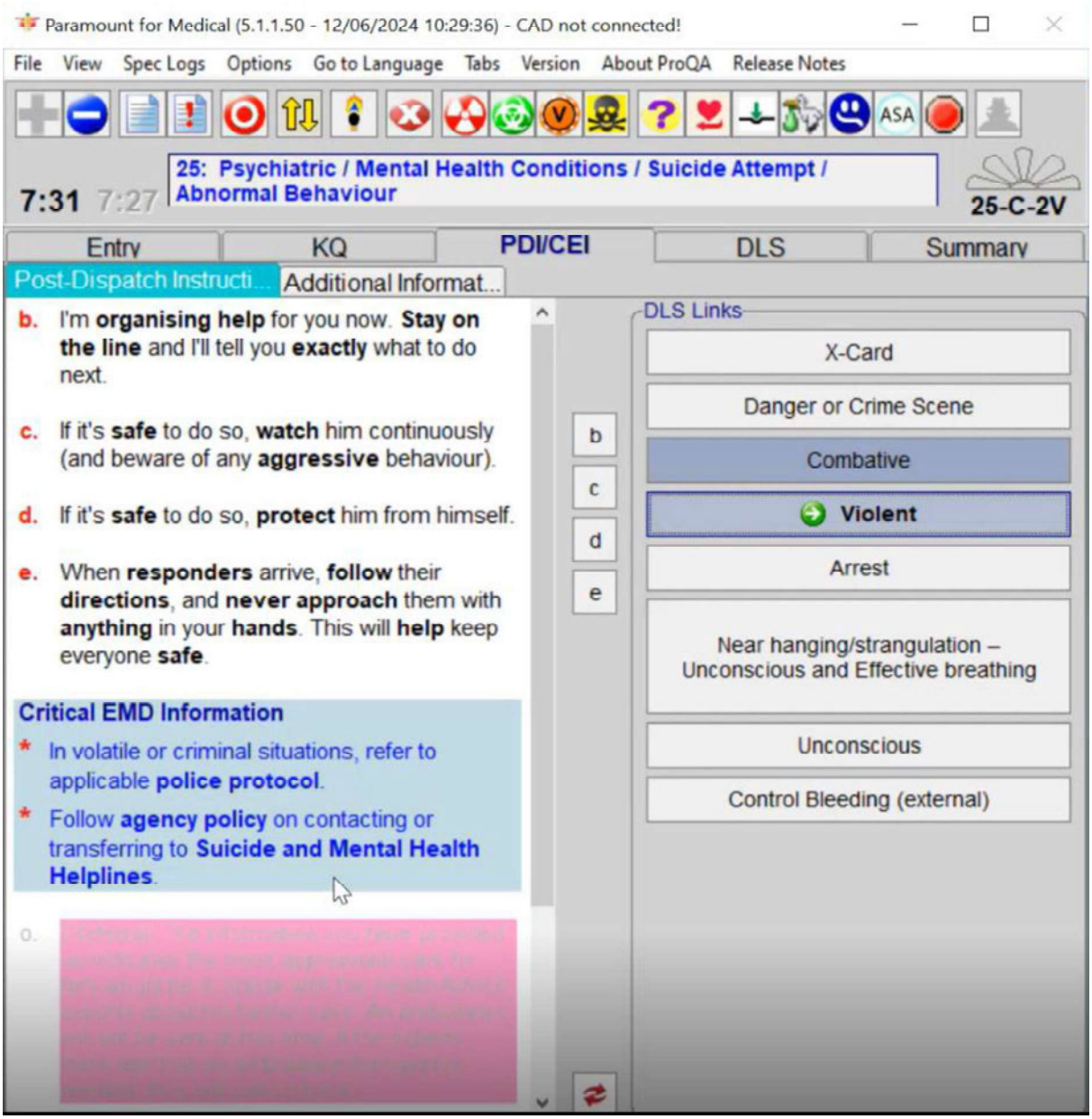
52. There are then instructions that the call handler can give to the caller. These include instructions such as: "Watch them continuously. Beware of aggressive behaviour." Now, again, because it's the police and it's fourth party so they're not with the patient, we would just ignore those. So, they'd probably just say: "I'm organising

Signature of witness … [redacted] ……..

help for you now." They'd exchange incident numbers so that we could contact them again if they needed to, and then that would be the end of the call from our control room.

53. I am asked to explain the 'Critical EMD Information.' The EMD information in blue is just for the call handler and not to be read to the caller. This gives hints, tips and/or instructions to the call handler.

Signature of witness ……[redacted]……..



54. I am asked how the above noted protocol differs where the call comes directly from scene. The difference with that is because they're on scene, they can answer those questions that we missed. In this particular scenario, for those questions that we

Signature of witness ……[redacted]……..

asked, for example: “Does he have a history of mental health conditions?”, they might or might not know that. They might or might not know if he's had a change in personality or behaviour, and they might or might not know if he's taken medication because it might have been something they've asked him. We'd ask those questions and then determine if that means a change of code from the answers to that. The biggest difference would be that, because the police are with patient, we'd expect the answers to the questions and not just “unknown”.

55. The outcomes, in terms of acuity levels, are all predetermined by our clinical response model group within the ambulance service itself. All of those codes have already had a determination of what that outcome is – whether it's red, yellow, amber etc. The dispatchers then dispatch a vehicle in accordance with that acuity, but they can't affect the colour if that makes sense.

56. I am asked, in the above noted scenario, what would be dispatched. Always in an emergency, it's the closest available vehicle, unless there's a specific skill set that's required. If we had an instance where the patient was requiring a paramedic for example and there was no paramedic available, then we'd still send a technician as a first response and then send a paramedic when they become available. So always it would be the first available vehicle.

57. So, a paramedic is essentially a technician with extended skills. Paramedics can do invasive procedures; we can intubate, so breathe for patients, we can cannulate and give drugs. Technicians can't give drugs intravenously; they can only give them intramuscularly. It's those extended skills that make the difference.

Signature of witness ……[redacted]……..

58. I am asked to explain the purpose of pre-arrival instructions. Pre-arrival instructions are those life saving instructions that call handlers can give to callers to help the patient until the crews arrive. These include CPR, airway management, childbirth, choking as well instructions on the administration of medications in a life-threatening emergency such as naloxone or epinephrine for example.
59. I am asked to explain if there are any specific pre-arrival instructions for ABD. No not specifically.

ACC: Clinicians – 2015 and 2024

60. I am asked whether clinicians within the ACC receive any additional qualifications and/or training to work within the ACC. That's completely separate from my role, and it's evolved since I joined the control room as a clinical advisor. To the best of my knowledge, they get trained in MTS, they get trained to understand the system and how to use their part of the system; how to upgrade calls, downgrade calls etc. and how to look at them. I can't say that definitively, but as far as I know.
61. I am asked whether the ACC clinicians are trained to recognise the signs and symptoms of ABD as at 2024. Not within the ACC that I'm aware of other than through MTS. Within clinical practice, yes. As a registered healthcare professional, you would get that as part of clinical practice. Otherwise, I don't know.
62. I am asked about the variety of calls that may be referred by call handlers to clinicians. I am asked, as at 2024, whether that would be dictated by the acuity level, or whether it would be based on symptoms, or a combination of the two. Yes,

Signature of witness …… [redacted] ……..

the position is still the same. The clinicians review calls which have been deemed suitable for further triage. Call handlers can refer any call to the clinicians where they need clinical support regardless of the acuity level. Except now I think, within that bulletin, we said if the police mention ABD, then they also refer that to the clinicians for further triage.

63. I am asked if I can provide examples of where ABD might be referred for further clinical assessment. The call handlers are trained that whilst they're not clinicians, if there is something that they just think that is not quite right, or they're not quite happy with something, the outcome doesn't really fit with what they're thinking etc, that sixth sense, or sometimes they gather a little bit of clinical understanding as they go through the role, then they are at liberty to refer it to the clinicians. Then the clinicians will review it and have a look at it. That applies across the board, not specifically for ABD, but for any condition where they feel they're not quite comfortable with the outcome. If they think something else is going on that the caller's not said or something they've heard that's made them suspicious, then they can refer anything to their clinical hub and the clinicians will have a look at it.

64. I am asked if there is anyone that ACC clinicians could refer to where a call was complex, specifically whether ABD would be flagged to a superior. If the clinician suspects ABD, they have the autonomy based on their clinical knowledge and skill, to upgrade the call to allow the dispatchers to allocate an appropriate crew. The clinicians also have clinical support within the hub if they need it.

Signature of witness . [redacted] .....

65. With reference to **SAS-00014**, I am asked how ACC clinicians would channel a call reporting suspected ABD as at 2024. I am referred to witness accounts of Sheku's presenting symptoms. I would still say the same as the answer I gave in relation to **SAS-00012** and **SAS-00013**. It would be an altered level of response, so that's not changed. Apart from this time it would be number 4 rather than 3, as was the last one as a new descriptor has been added.
66. I am asked to explain the acronyms 'CSDR' and 'CSDA' within **SAS-00014**. Those are the override codes that the clinicians would use. So that's just a Clinical Support Desk Red and a Clinical Support Desk Amber, and all that means is that from a dispatch perspective, when it appears on the screen, it shows that a clinician's triaged it and that's the response they've determined is appropriate.
67. It is highlighted that there is a red warning box outlining the description of ABD. I am asked whether I know why that has been added. The warning box is there so that the clinicians are alert to those symptoms.
68. It is noted that the list of places that a patient would be conveyed to has been extended. I am asked if I know why and what benefit they might bring to someone suffering ABD. No, I don't know. My educated guess would be that we now have access to more referral pathways.
69. I am asked whether I have an idea of the additional circumstances that now, as at 2024, would be referred for additional clinical triage that would not have been referred at 2015. The only additional ones I could think of is within the Clinical Hub. I don't work within the clinical hub anymore and it's changed significantly since I

Signature of witness … [redacted] ……..

left it, but we have calls of lower acuity where we wouldn't ordinarily expect to send an ambulance response. Those patients need further triage so that we can refer them to hospital themselves or give them some self-care advice rather than sending an ambulance. Additionally, the clinicians review calls that are of a lower acuity level which are waiting in the queue for an ambulance to become available in case they need to be escalated.

70. I am asked where the Clinical Hub is physically located within the ACC. They sit within the same room as the call handlers, and they always have been. The only exception to that is that we have some Advanced Practitioners who work outside of the ACC. They work remotely. That's just by virtue of their location, or where they stay. Post-COVID, we've had much more opportunity now to work remotely than we ever did before so some of those Advanced Practitioners will work remotely from ambulance stations.

71. I am asked whether the Advanced Practitioners are the same as the Advanced Critical Care Practitioners ('ACCPs'). I'm not sure; I don't deal with that section of stuff in terms of their skill sets.

72. I am asked whether the ACCPs have an assessment and triage function, or whether they would be deployed to an incident. Again, that's within the Clinical Hub and is, therefore, out-with my remit. I couldn't say that for definite.

73. I am asked whether there is anyone else within the ACC that might handle calls. Other than the different types of clinicians, we have some GPs that work within the

Signature of witness …… [redacted] ……..

Clinical Hub now. We have nurses as well, so we have a broad range of skill-set within the Clinical Hub.

Priority level and timescales: 2015 and 2024

74. I am asked which Protocol 9 or 32 (**SAS-00012** and **SAS-00013**) would be the relevant Protocol for ABD at 2015. It depends on the symptoms being exhibited.
75. I am asked to refer to **SAS-00012** and **SAS-00013** and, using these Protocols, to explain which priority would be assigned to a suspected ABD at 2015. Based on the information previously provided of witness accounts of Sheku's behaviour, I'd have probably come out with an altered conscious level because you're saying he's not behaving normally, he's not completely awake, he's not responding as you would expect, so that would be an altered conscious level, which would be in Option 3 within the second box on the left-hand side. The outcome of that is 'FtF now' so that's a face-to-face assessment in an emergency department in under 20 mins.
76. I am asked to explain what priority level would be allocated were the call to be processed under the mental illness protocol. Yes, it would be the same as the above. It would still be an altered conscious level, which would be red. The difference between the two, my guess, would be that the mental illness card is for patients who we know have had mental health issues. The "behaving strangely" could be caused by someone with a urine infection – for example, your elderly patient who's not behaving as we would expect them to.

Signature of witness …. [redacted] ……..

77. I am asked if the response times are aligned with service-wide targets for certain conditions. Not to my knowledge. They're more of an indicator of a desired time to get them there and not specifically what they need to do, or which vehicle because the clinicians won't have any influence over that.

Responders

78. I am asked to consider the reported symptoms from witness accounts and to detail who would be dispatched to a call. It would be whoever's available. Again, it would very much depend on their symptomatology, so it depends what we are presented with, but for a reduced level of consciousness, behaving abnormally, they would dispatch the first available vehicle, and then that vehicle can request someone else if that's what they require, unless the clinicians get sufficient information to suggest it was ABD. So, if they suspect that as the diagnosis, then they could say to the dispatchers, "Could you make sure you send a paramedic to that, or send an AP?" or whatever, because that's what they're going to need, and then the dispatchers can start to think about who they've got that's available.
79. I am asked where the case was complex whether a paramedic on scene could request someone with a more advanced skill-set or additional resources. Yes absolutely.
80. I am asked whether, for ABD, there would be a preference for a certain responder. In the first instance, depending on the acuity level, if it came out as the red, "face-to-face now," it's whoever's available. But if we have specific conditions where we

Signature of witness [redacted] .....

know we're going to need a paramedic, for example, then there are specific codes that say, "Paramedic essential," and then a paramedic will be sought and deployed. We don't have a specific code for ABD so, again, it depends on what it was coded as whether that would be an outcome that would be seen by the dispatcher, or whether they would be advised by a clinician that that's what was needed.

81. I am asked to confirm whether ABD would just be categorised based on symptoms and then assigned a code based on acuity level. Yes, and the higher the acuity, the more requirement there is for a paramedic.

82. In theory, an ambulance technician could be deployed instead of a paramedic.

PIRC-01390 – Transcript of calls between Police Scotland ACR to Scottish Ambulance Service ACC

83. I am drawn to page 2 of this document, 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."

Signature of witness ……[redacted]……..

I am asked whether the restraint followed by the request for an ambulance for Sheku should have triggered further questions by the call handler. Back in 2015, our process for dealing with police calls was slightly different. We have a process for dealing with calls that come from police control rooms. In recognition of the fact that it's coming from a police control room, from someone who is not on scene and therefore can't see the patient, then we recognise that we cannot always ask the questions regarding what's happening to the patient or specifically around some of the things that we would normally ask. The call handlers have what's known as the SEND protocol, which was used for our control rooms, police and fire, and in that we reduced the number of questions accordingly. There was a minimum amount of information that was requested from that, and that was the scene safety questions, so anything that would adversely affect our crews to make sure we kept them safe, and any questions regarding the priority symptoms. We asked if the patients were conscious, if they were breathing, if they had chest pain, or if there was any significant haemorrhage, and those are priority symptoms. Outside of those, we didn't ask any other questions.

84. Now, that process has changed slightly. We still receive calls from police control, and they continue to be processed using the SEND protocol but in addition, we now expect police officers to phone us from scene, and if they do, we process the call as we would any other 999 call. The advantage of that means that we: a) get a better picture of what's going on at the scene, because they're with the patient; and b) we can give instructions for CPR, for dealing with the patient, etc., and it's

Signature of witness ….. [redacted] ……..

a more accurate picture than coming from a fourth-party caller. So, that process has improved.

85. I am asked if it is the default position that calls should come directly from scene as at 2024. Yes, it is where possible.

86. I am referred to PIRC-01390, at page 10, where it states:

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

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

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."

Signature of witness …… [redacted] ……..

I am asked whether there should have been further questions asked by the call handler to inform pre-hospital care by responders and to inform the ER staff at the hospital, where appropriate. The call handlers have no influence on that whatsoever. They did as I would expect them to do. The call has come via control, so they've asked if there's an officer on scene. Back then we could have spoken to them on their airwave radios and talked them through CPR, if that's what they wanted. They've obviously declined. Again, different now because we could use a phone to call the officer directly, but they've obviously declined at that point. From a call handling perspective, there's nothing else they would do. They don't contact hospitals or anything else. That would be done by dispatch. So, if the crew arrive on scene and they're doing CPR, they would contact the control room and say: "Could you ask for standby at the hospital?" and then the dispatchers would phone the hospital and ask for a standby and give them an ETA of the crew, but that's not a call handling function.

87. I am asked whether the call handler would pass any information on to the emergency department where the patient was suspected to be suffering from ABD. No, because again they don't have any influence over the information given to a hospital. That would be gathered by the clinicians on scene and the clinicians would give that information to the hospital.
88. I am asked whether ACC clinicians would collect a history about the patient to provide to the responders and/or the hospital. Certainly, the clinicians have free rein to ask whatever they want really, and clinically, based on their own knowledge and skill set. Then they would pass any relevant information on to the attending crew.

Signature of witness ..... [redacted] .....

89. I am asked whether ACC clinicians were trained to recognise the signs and symptoms of ABD at 2015. Not to my knowledge, but I can't say that definitively.
90. I am asked whether ACC call handlers are now trained to recognise the signs and symptoms of ABD. Not specifically, other than being made aware of the symptoms but call handlers are not trained to diagnose patients.

SAS-00002 – Police calls made directly from scene – published 2023

91. I have explained that this is the relevant guidance document for call handlers where they receive a call directly from police on scene. I have explained that now where ABD is mentioned by police officers, call handlers should immediately refer to this document I am referred to page 2 of the above noted document, where it states:

"On reaching the Scottish Ambulance Service, police calling from scene will be given the following message "This is the ambulance service police on scene line. If the patient is not breathing, not conscious, choking, is pregnant, fitting or having an allergic reaction please press 1. For everything else please press 2".

Calls presenting to option 1 will go to emergency qualified EMDs only whilst calls presenting to option 2 will present to HCP/SEND call handlers."

I am asked how suspected ABD would be processed using this protocol. The difference between them is the skillset of the call handler that will answer the call, and it's not a reflection on their ability to process a call. What happens is when we train new call handlers, when they're newly qualified and they come out of training, they go into the control room and spend

Signature of witness … [redacted] ……..

a period of time in the control room taking Health Care Professional ('HCP') calls only. So that's from healthcare professionals, they don't deal with emergency calls from the public. That's the first part of their training, and that means that they can take calls in a non-emergency environment where they get the time to think, and process calls and get used to the system.

92. When they've dealt with HCP calls then they do further training to deal with emergency calls from the public and then they deal with those. The difference with the options is that for option 1, because we're talking about immediately life-threatening conditions, that will go directly to an emergency call handler who's trained to give those instructions. That would be for all life-threatening emergencies, so where they're not breathing, not conscious and we're going to give CPR instructions, all those things that can't wait will go directly to an emergency call handler. For everything else, it will go to an HCP call handler and that call handler will process the call in exactly the same way, but what they can't do is give those life-saving instructions, which is why there's an element of urgency that makes it go to option 1.
93. The SEND protocol will come under option 2. If it's not one of those conditions above it will go to option 2 and then the HCP call handler will take the call and will process it as it would any other, exactly the same as an emergency call handler they just won't give those instructions at the end. If those instructions are required, then they would pass the call on to an emergency call handler who would give those instructions, and they wouldn't themselves. So that's the difference between options 1 and 2.

Signature of witness …… [redacted] ……..

94. In terms of the SEND protocol and the police, they would just be dealt with on option 2. However, if when the police phoned and we were at that point that you suggested where the patient's no longer conscious, not breathing, they would select option 1 and get an emergency call handler and they would talk them through CPR.
95. If they mentioned ABD, without the above noted priority symptoms, it would be directed through Option 2 on the police line. It would go to an HCP call handler, and they would just process a call as they would any other.
96. **SAS-00002** mentions that the HCP/SEND call handlers:

*"should also **ask the police caller all Key Questions**, and not restrict their questioning to scene safety and priority symptoms as they do with SEND calls from police controls. HCP call handlers should **also give any PDIs that are possible and appropriate** when police call from scene."*

PDIs are post-dispatch instructions. These are instructions to prepare for the arrival of the crew such as gathering medication, unlocking doors, putting away pets etc. The call handlers would only read the instructions that are appropriate and apply to that specific call.

I am asked what the key questions would be if ABD was mentioned as at 2024, as this document came into force in 2023. Those are the key questions that are already pre-set by the Academy on the protocol itself. The difference now would be where the call is coming from.

Signature of witness … [redacted]……..

If it is coming from the police control then the SEND protocol would be used but if the police officer was calling from scene, they would be asked all the key questions on the protocol.

SAS-00003 – JRCALC Guidelines - Trauma Emergencies – Adults 2013

97. This is an excerpt from one of the previous JRCALC Guidelines. I am referred to the following passage:

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

The Inquiry has explained that it understands that when it comes to the working relationship between SAS and PS that the police ultimately lead in restraints and that SAS considers them the experts in those scenarios. However, it is noted that sometimes responders can ask police officers to adjust restraint where they feel that the restraint may be impeding treatment and/or exacerbating the patient's condition. In these scenarios, police will consider whether it is safe and appropriate to do so. In view of this, I am asked whether any instructions on adjusting the restraint would ever be given by call handlers. No, it's not. That guidance that you're looking at is the JRCALC guidelines which are specifically for clinicians and the call handlers are not clinicians.

Signature of witness .[redacted]……..

The other thing is they're not on scene, so they can't see what position the patient's held in, nor are they trained to know whether that's a good position to put them in or not. As I say, they're not clinically trained to assess the patient's airway and breathing in any case, so they wouldn't know whether the patient's breathing was adequate or not, other than from the specific questions that they ask in the protocol. The mention of restraint alone would not trigger instructions by the call handler to raise awareness of checking airways.

98. I am asked whether clinicians within the ACC could ever have a conversation with police officers about restraint. They could have. So, you could have a conversation around: "Is the patient's breathing effective? What colour are they? How's their airway doing?" You could even ask: "How are they being restrained?" if there was a reason to do that. Again, because we're in a non-visual environment, we can't see what's going on at the scene. We're very much restricted by the information that we're given. So yes, you could ask the questions, but we would never know whether the method of restraint was appropriate or not, because we wouldn't be able to see.

99. I am asked whether delivery of instructions would differ depending on whether the call is coming directly from police on scene versus through police ACR. We don't give specific instructions to the control room because they're not with the patient. If we were going to give instructions – CPR instructions, area management, etc. – we'd want to speak to someone on scene so that we could get a really good idea of what position the patient's in, how they're doing, what's happening to them, so

Signature of witness .... [redacted] .....

we know whether what we've done is effective or not. Historically, we have been able to give instructions via the control room. It's very difficult because then you're giving them three-way instructions and you've no idea whether they're working or not. So ideally, we wouldn't give them through the control room. We would give them directly to the police on scene, which is why they ask for a phone number.

SAS-00007 – JRCALC Guidelines – Acute Behavioural Disturbance – 2022

100. This is an excerpt from the JRCALC Guidelines 2022 on ABD. I am referred to the following passage:

> *"In a two-year audit by the London Ambulance Service for cases where appropriately trained clinical care paramedics responded to ABD, 62% patients were managed using only verbal de-escalation followed by standard care."*

I am asked if call handlers are trained to verbally de-escalate a patient. If it was a first-party caller with a mental health issue, ABD notwithstanding, then they would verbally de-escalate if they were looking to cause themselves harm, etc. When it's a second-party caller though, and it's the police that's calling with the patient or several people with the patient who are not the person that's on the phone, then the expectation is the police would deal with the de-escalation part of it and not the call handlers.

101. I am asked whether ACC clinicians are able to give instructions to a police officer where they suspect ABD. Potentially. I suppose it's something they could

Signature of witness …. [redacted] ……..

say, have you tried talking to them to see if de-escalation would work before they do anything else. I guess from my perspective, it would depend where in that journey they are when they phone. Have they tried all of that already? Have they physically restrained the patient? Because if they have, that would suggest that it's not worked. I guess it depends on what they're presenting with when they phone.

SAS-00009 Advanced Critical Care Practitioner Pocketbook

102. I am asked whether an ACCP would be deployed where ABD is suspected. Definitely not by a call handler. The clinician might, depending on the circumstances, if they needed medication for calming, such as a sedative. If they recognise the fact that they were needing a sedative, then they might recommend to the dispatcher that they're deployed, but the clinicians themselves wouldn't deploy them.

103. I am asked whether I am aware of the treatments that ACCPs can administer over and above what a paramedic. I'm not sure.

SBPI-00362 – Statement of Inspector James Young

104. I am referred to Inspector Young's statement to paragraphs 37 and 38. These paragraphs describes scenarios where ABD was suspected by Inspector Young but where an ambulance would not attend. He states that he cannot be sure whether the attendance was refused on ACR's end or ACC's end. I am asked

Signature of witness … [redacted] ……..

whether there are any circumstances where ABD may be reported but the call handler wouldn't necessarily allocate a code to attend. I think back in 2015, ABD wasn't so readily recognised, and again, our call handlers go by the symptoms they're presented with. Depending on what the police told them, we determine the code that was applied and then the outcome, and the call handler has no opportunity to change that in any way other than to pass it to a clinician to review. The outcome in terms of not sending an ambulance response wasn't a decision made by the call handler itself, they were still following the algorithm, so it was very much symptom- and information-dependent.

105. I am asked whether there are any circumstances as at 2024 where an ambulance would not be allocated to attend. I can't say definitively because, again, it's going to depend very much on the symptoms that they describe when they phone. I think we're much better, or much more attuned, now to ABD; the call handlers know to refer them to the clinicians. So, if the police were to mention that as a possible diagnosis, then hopefully they would do what they're supposed to do and send it to the clinicians.

106. If the police didn't say ABD and just gave us a collection of symptoms, then the outcome would be according to the symptoms and I couldn't say what that would be as it would depend on whether there were any life threatening symptoms first and then the answers to the subsequent questions.

Signature of witness …. [redacted] ……..

Joint protocols between SAS and PS

107. Aside from **SAS-00002**, I am asked if I am aware of any other joint protocols which consolidate police and ambulance service response to ABD. Not that I'm aware of, no.

Targets

108. I am asked whether there are any SAS-wide targets for response to suspected ABD calls. No, there are not as far as I'm aware.

Involvement with the investigation

109. I have not had any involvement with the investigation into Sheku's death.

Contact with other witnesses

110. I have not had any contact with any other witnesses to the Inquiry, apart from my colleague, Keith Colver.

Media

111. I've not been following the Inquiry on social media. I'm aware of it because I worked in Kirkcaldy.

Date October 29, 2024 | 6:07 PM GMT

Signature of witness … [redacted] ……..