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Regulation 28 – Report to Prevent Future Deaths

This Report is being sent to:

1. Chief Constable, Northumbria Police, Police Headquarters, North Road, Ponteland, Newcastle upon Tyne NE20 0BL
2. Independent Police Complaints Commission, PO Box 694, Wakefield WF1 9NU
3. [redacted]

1	**Coroner** I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.
2	**Coroner's Legal Powers** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**Investigation & Inquest** On 11th January 2012 I commenced an investigation into the death of Vincent Gibson, aged 50 years. The investigation concluded at the end of the inquest on 13th February 2014. The conclusion of the inquest was the deceased died from multiple injuries sustained in a road traffic incident on Whiteleas Way, South Shields on the 7th January 2012 as a consequence of a collision with an emergency vehicle travelling in response to a Grade 1 incident.
4	**Circumstances of the Death** The deceased in the course of crossing Whiteleas Way, South Shields was struck by a Police vehicle travelling at speed with audible warning and lights activitated and responding to an emergency call identified as an imminent danger to life and graded accordingly. The deceased fatally suffered multiple injuries.
5	**Coroners Concerns** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it I my statutory duty to report to you. The matter of concern are as follows:-

1.CORONERS CONCERNS continued

The evidence in this process centred on the role and actions of a number of Police service employees engaged in the deployment of Police vehicles responding to an emergency call, their identity and a brief history of their role follows :-

CALL TAKER

1. The evidence presented by [redacted] confirmed her training and practice in her role as a Call-Taker on the 7th January 2012 in the Southern Communications Centre of Northumbria Police in South Tyneside.
2. It demonstrated her clear understanding of the Grading system and her responsibility to log and grade calls received by her.
3. On the basis of the evidence of the call received, from a recording, a transcript of that call and the evidence of [redacted] there is no dispute that she responded to and graded the call correctly.
4. She continued thereafter apart from a break initiated by the caller to stay in contact with the caller until he was ultimately met by a Police Officer sent to the scene to escort him from the field where he apparently was.

RESOURCE CONTROLLER DOVER

1. The log [redacted] initiated and prepared and the grading of the call was then passed properly to the Resource Controller in the Centre , [redacted]
2. It was [redacted] initial task having noted the nature of the incident and grading to identify and allocate resources in response to this incident.
3. She initiated that part of the task by putting out a call to any vehicle in the area to begin travelling pending "tasking".

[The word "tasking" is in parenthesis because it appears to mean different things to different witnesses and indeed the same witness from time to time.

Tasking suggests in this context that the allocated resource should begin travelling pending receipt of further information and/or instruction.

An alternative meaning suggested that tasking equated to the allocation of a resource or then again actual identification of the resource].

4. Given the information PASSED initially to each resource responder to that initial call - the term "tasking " more reasonably appears to convey the first meaning - the allocated Officer would be conveyed further information or instruction at some stage later and during their travelling to the point of response.

5. The Resource Controller clearly indicates to each responder PC [redacted] and PC [redacted] that to PC [redacted] "we have more digging to do" and to PC [redacted] his Sergeant, (Acting Sergeant [redacted]) would contact him later.

6. It is important to realise that all of these messages are going across an open line, they are not one to one communications and were available to all those who are connected or tuned in to this transmission to receive and understand.

In the event, no further direct communication is made to the responding crews before the collision.

7. The Resource controller tasks the Bravo 1 supervisor Acting Sergeant [redacted] to telephone the caller with an intention to obtain further information. He is unable to make contact because the caller's telephone is engaged - the caller is still talking to [redacted]

8. [redacted] is in the same room as [redacted] - she was unaware of the fact that this conversation is still going on.

9. She is however aware of additional information being put on the log and this information is clearly being received from [redacted] and is obviously being gleaned from somewhere.
10. Acting Sergeant [redacted] is in the building - that is to say the Divisional Headquarters where the communication is located on an upper floor. He is on the ground floor but has no immediate access with the Communications Section.

The Acting Sergeant takes no active role in the process after his attempted telephone call save for an entry he places on the log.

THE RESPONDING OFFICERS
1. PC [redacted], Special Constable [redacted], PC [redacted] and PC [redacted] are Police Officers stationed in Southside division, Divisional Headquarters. They form part of a night shift allocated to the sector known as Bravo One which essentially equates geographically to the boundaries of South Shields town on the night of the 7th January 2012.

2. After parade and whilst preparing to leave the station [redacted] call over the airwaves for any vehicle to respond to the concern for male, lead at 22.18 PC [redacted] responding and then at 22.19 PC [redacted] responding.
3. [redacted] allocated both crews to the task.
4. Both crews were located at the Divisional Headquarters in South Shields at this time. They were beginning their night shift.
5. [redacted] did not know where they were but asserted that she presumed they were, it being a time for changeover.
6. In the fullness of time she would have received formal confirmation of their presence and the allocated vehicles they would have been using that night in order that she could update her record and more significantly a plan, an electronic plan would also identify the resource and identity of the vehicles and officers in question.
7. The crews did not have any apparent direct discussion with one another and again there was no apparent discussion with Acting Sergeant [redacted] their supervisor about their volunteering for this task.
8. The officers did not between them as a group plan their route but they utilized their personal satnavs owned respectively by PC [redacted] and PC [redacted] to identify the route.
9. PC [redacted] lead the exit from the Divisional Headquarters. PC [redacted] followed driving and following in the second vehicle.
10. The crews received no further direct communication from anyone en route.
11. All members of the crew asserted they knew what was required of them : On arrival at the address or presumed home of the caller – to determine if he was there - enquire of anyone there as to his whereabouts - report back to the headquarters on their arrival - to initiate a search of the area.
12. The route and the speed of the travel to the address was a matter for the drivers of the Police vehicles and that in accordance with their training as Police Officers and Police drivers to respond to Grade 1 designated responses specifically.
13. It was for them, the drivers, to assess and risk manage the task before them.
14. Their understanding was given the grading of the incident they were required to respond to the address as soon as possible and in any event, within 10 minutes. [redacted] in the course of her interview in this matter did not know precisely how far or how long it would take her to get to the address that she had been given. She estimated between 15 and 20 minutes.

15. Once the log is created anyone connected to the system can access it and add to it by typing in an entry and clearly can read and understand what is developing. The travelling Police Officers do not have that facility.

ACTING SERGEANT ROBINSON
1. The Officer is the Sergeant in charge of a group of Officers working in the secter bravo 1 – South Shields Town .
2. He briefs his sector officers serving with him on the night shift as to the proposed night's events and plans at the commencement of that shift at 10.00 pm.
3. He is aware of the call for assistance initiated by the Resource Controller.
4. He is not active in the process of resource allocation nor in the formal agreement by his sector

officers in their involvement in responding to this call.

5. The Acting Sergeant takes no active role in the process after his attempted telephone call and an entry he places on the log which reads at 22.21 by 8815 " PR to attend H/A a.s.a.p. to obtain further inform from family and check on welfare of child mentioned on log" . The purpose of this entry is an information for others reading the log as to what the deployed officers are to do in the event of those officers making an enquiry in his absence as to their role or others needing to know what the officers were to do.

6. The reference to the child is entries which appeared in the log that there had earlier been child concerns and at 22.19 that he has a 5 year old daughter called (name deleted). In the event the child appears not to be there and further information is received on that specific point.

7. The Sergeant's next active role in this incident is when the collision occurs , he is alerted to it and responds to that incident.

THE LOG

1. This is an electronic record initiated in this case by [redacted] and in its form having been created can be accessed and added to by those who are permitted to do so. Those able to access the log on reading it would have an understanding of the developing nature of the subject of the log.

2. Entries are recorded chronologically and they can be inevitably a slight time delay between the matter being recorded as an incident or development, actually appearing after typing on the log. It is apparent from the log that some entries are out of sequence in all probability because the author has commenced their entry before or completed the process of their entry before the author of a chronologically earlier event.

THE SOUTHERN COMMUNICATION CENTRE

1. Located as part of the complex which houses also the Divisional Police Headquarters in South Tyneside.

2. The centre accommodates both call takers and response controllers within the same large room.

3. There are in addition to call takers and response controllers , supervisory officers situated within the centre and these officers can and do when necessary take charge of or manage a developing incident where appropriate.

4. One of the supervising officers on the night of this incident was a Sergeant [redacted] and she was informed of this incident by the Resource Controller but only on the basis of it being alerted to its existence as opposed to being invited to actively engage in its management or supervision. Such notification is made by a grading of the passing of the log to her as a grade 2 incident.

5. The supervisory staff have an overview from a raised position in the room of the staff in the room, including the call takers and Resource Controllers.

6. The supervisory staff would not be aware of the ongoing telephone communication being had between [redacted] and the caller unless alerted in some particular way as to the fact of that call or its duration or content.

THE MATTERS OF CONCERN

1. The matters of concern identified by this history centre on an all too apparent lack of co-ordination of the essential elements of management, monitoring and control needed to effectively respond as one would reasonably expect to a properly identified and graded serious incident.

2. The caller using his mobile telephone contacted the 999 operator seeking assistance. That call was properly transferred to the Police and received by [redacted] a trained call taker. She identified the matter for what it was an apparent danger to life and graded it accordingly.

3. She logged the incident and despite the reticence of the caller to identify himself or his whereabouts she traced and identified him through his phone to an earlier communication by that phone and through that earlier incident identified the caller and his apparent address. The log she prepared was based on this address. She was told by him he was not there. He was in fact saying he was on his back, looking at the moon in a field. She dutifully recorded that.

4. The log was raised on the identified home address – because technically it had to be raised on an address otherwise it would technically have to be initially raised on the actual communication department itself.

5. The address became accordingly the focus of and simply put the only obvious starting point for an investigation in the mind of the participants. The fact that he was saying he was in a field was noted but not prioritized in any way at that stage as a basis of a plan to find the man. The log once created and with all this essential information on it was passed to the Resource Controller for allocation of Police Officers and resolution of the incident.

6. Much more significant than all the other facts which appeared on this log directly was the omission of the fact at any stage before the incident of the collision that [redacted] was in continued conversation with the caller.

7. [redacted] was in the same room as [redacted] and i[redacted] had known of the continuing conversation one assumes, she could have planned accordingly. [redacted] clearly appreciated that contact with the caller was an essential way of trying to find out more positive information about him and effectively plan for his help and support.

8. As the Resource Controller and the recipient of the initial log and graded incident she is the obvious point of direct contact for such essential detail. She is also the obvious conduit for not only the fact that the caller is still talking to the Call Taker but to understand the tone and content of that conversation and analyse the level of distress if any, the caller is continuing to demonstrate.

9. If she is unable to personally evaluate it, others within a supervisory capacity should have been able to do so and to act and plan accordingly.

10. It is of primary importance to keep the grading of the incident under review and that with the benefit of essential and relevant information. Similarly the allocation of resource and the tasking of that resource again demands relevant and essential information sufficient to ensure the effective and safe discharge of and completion of, the task in hand.

11. The two crews were ignorant of both source and content of such essential and relevant information and were being asked to risk assess a task in the absence of such essential relevant and critical information. With that critical information available to them they would be in a better position to determine more safely the speed of approach to the task - which they essentially perceived was to visit a house where the caller was believed to be but was not.

12. If Acting Sergeant Robinson had as tasked been able to speak to the caller, he would have been able to advise the travelling Officers and instruct them accordingly.

13. It is not clear that either [redacted] or Acting Sergeant Robinson was :-
a) Aware of his or her role
b) Nor does it appear others were clear as to the role of the Sergeant or the resource controller.
c) It is not clear that either of these individuals had a clearly defined role prior to this night in the managing, monitoring or controlling of this incident.

Whatever the roles of these individuals was - whether they were joint or mutually exclusive , that role - their roles - was an essential to the discharge of this grade 1 incident safely and effectively.
As far as Sergeant Robinson was concerned, I am of a view that he was not the manager of this matter. He was not in a position to control or effectively monitor events.

14. That failure to clearly define an identifiable role and consequential confusion over roles, add to a lack of clarity and lead to a lack of effective co-ordination of the essential tasks set within this matter.

THIS INQUIRY
This Inquiry has not been directed towards the preventing or inhibiting the ability of the responding of emergency vehicles at speeds to life threatening events (ie Grade 1 incidents) but has sought to examine how the management monitoring and control of such incidents is co-ordinated and that in a

way which reflects the commendable observation on the Code of Practice for Drivers of Vehicles Used for Police Purposes issued by Northumbria Police which states "no emergency is so great as to justify an accident"

THE QUESTIONS AND ISSUES UNDERLYING CONCERNS

1. Who was in charge of this incident and its development from its inception ?

2. Was it the communication room staff ? and if so, which member of that staff was in charge.
3. Was it the sectors supervisor ? and if so, what information did he have to make essential and basic judgments on ,
a) Appropriateness of the grading
b) The continued urgency of the situation
c) Plan a response
d) Effectively identify the nature of that response
e) Maintaining a risk analysis which reflected at all times on the safety of (i) the caller (ii) the safety of deployed crews (iii) the nature of the response and safety of members of the public who may with reasonable and thoughtful insight be identified as being caught up in the response.

4. The communication staff are the primary source of incoming and outgoing information. They are in a pivotal position which lends them to the management, monitoring and control of an incident from its inception to its conclusion. They need to be effectively resourced both as to trained personnel and equipments.

5.Rules of practice, ie protocols need to be clear and unequivocal identifying robust rules of procedure identifiable lines of communication where appropriate but at all stages in the identifying of the individual in the management, monitoring and control of an incident who can be properly identified as in charge of the incident in hand.
6. Training is important as is experience and practice but it should never be a presumption or presented as an excuse for a lack of clear and unequivocal instruction and good information, on the day and in specific response to a specific incident.
7. Identifying an allocation of resource should not be a spontaneous response to a demand but a reasoned and considered response to effective planning and to positive resource evaluation.
a. Self-selection borne of enthusiasm and worse, boredom does not make for a balanced plan and safe approach to a critical incident. Officers in this case were able simply to call in, identify themselves as available and willing.
b. The resource controller although she had an electronic map which could identify the whereabouts of resource did not use that map it falling out of favour and being judged not fit for purpose. Accordingly, at no stage was any resource identified even if it was available at a closer proximity.
c. Staff must be confident in the electronic aids given to them.
d. They must be effectively trained in them and those aids and their accuracy and effectiveness constantly under review.
e. It is understood that at the time of this incident whilst the map was judged to be not fit for purpose, its replacement was under review , nothing appeared to be in place to readily identify the shortcomings of the map.

8. It is difficult to judge what is worse, having an ineffective tool or no tool at all and in the absence of a tool, having no effective backup or resource management.
9. Electronic aids are a benefit not only to Central Control but also to responders and such electronic aids should eliminate any issue or debate around the fact as to route and leave the crew speculating as to the position, route or speed.
10. Electronic aids should (a) readily identify the location (b) pre-plan the route (c) determine a safe and where appropriate speedy passage. In any event, any electronic aids and/or systems must be fully integrated being identified for the purpose they are intended to serve.
11. Speed was a central issue in this matter.

a. Speed as an important element appears to have been borne of a conflict of notions within the mind of crew members as to what was required by way of a response time to this Grade 1 incident.
b. The Officers view was that speed was dictated by a need to reach the destination as soon as possible and in any event within 10 minutes. Senior Managers however highlight that the time 10 minutes was a performance indicator, utilized subsequent to the incident to evaluate the effectiveness of the response and consequently the service given to the public.
c. It was not to be perceived as a "pressure" on the crews to respond at speed.

12. Such an apparent conflict of understanding of what that time response meant or means when attached to a grade 1 incident or indeed a grade 2, or any of the other five graded responses underlines an essential need for this process to be taken into some effective control and to be the subject of particular training and clear understanding on the part of both management and staff.

CONCLUSION

It was stated in evidence and it is readily acknowledged that when a person's life is at risk it is a matter of professional pride to go to the aide of that individual as quickly and effectively and as safely as possible.
It is a matter of pride not only for the individual but as a service as a whole.

1. These laudible aims can be achieved with the benefit of effective management, monitoring and control and on now on the basis of evidence given with the availability of electronic aids which are available.
What is not good practice and gives rise to concern is the apparent over-reliance on presumed skill sets from periods of training and years of experience and dare one say, a successful completion of a number of incidents without any apparent failing. Each incident merits appropriate levels of individual management, monitoring and control.

2. Between 10 and 12 years ago, Hospital Trusts were encouraged to engage in a transparent review of any sudden untoward incident which may occur within their establishments. Some are better at this than others but the best readily embraced the principle of early internal investigation, the identifying of the facts and witnesses and as part of the process to determining what went right and what went wrong.
Out of that process comes a meeting to identify and plan for the implementation of lessons learnt. Government has indeed only recently encouraged health services to be even more transparent in their public dealings. It is a matter of some concern that this is not an apparent practice of the Police Service even though they have a Professional Standards Department, which is clearly designed to address and respond to issues around Professional Standards and that not only in an objective but effective way.

3. There was an independent investigation carried out by the IPCC with the Durham and Cleveland Force dealing with the Road Traffic aspect of this collision. The management monitoring and control of this incident was it would appear to have been the subject as a reference at one stage which were not embraced or subsequently fulfilled. It is my view that this was a missed opportunity and it is noted that the Force's representative at the Inquest in response to the evidence of the IPCC investigator [redacted] invited any observations the Commission might have out of which learning could possibly be gained.

4. It is my hope that the IPCC will review the evidence in this matter and this Regulation 28 report and call upon their experiences of other enquiries of a similar nature and advance to Northumbria Police the benefit of such learning as may be appropriate.

5. It has to be acknowledged that one of the witnesses at this hearing, Detective Chief Superintendant [redacted] clearly indicated that a number of lessons have been learned and actions undertaken , around issues and factors reflected on since this incident and the preparations for this Inquest process. It would be useful to note in a coherent and detailed way, exactly what has been achieved to date and is yet still planned but will ultimately be implemented.

6	**Action Should be Taken** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**Your Response** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st June 2014. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**Copies & Publication** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons , the family of the deceased. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Date: 1st April 2014 **Signature:** **Senior Coroner – Gateshead & South Tyneside**