SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2024] FAI 18

FAL-B448-22

DETERMINATION

BY

SHERIFF JAMES WILLIAMSON

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the deaths of

JOHN ALEXANDER YUILL

and

LAMARA NATALIE BELL

Falkirk, 10 April 2024

DETERMINATION

The Sheriff having considered the Joint Minutes of Agreement, the evidence, and the submissions of the parties, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the Act") that;

F1. In terms of section 26(2) of the Act, when and where the deaths occurred:

John Alexander Yuill was born on 8 August 1986. He died between 06.00 and 06.50 hours on Sunday 5 July 2015. His place of death was to the side of the M9 Edinburgh to Perth motorway eastbound, junction 10 to 9 at a point 125 meters

southeast of the New Line Road Overbridge, Bannockburn near to its junction with the M80 motorway southbound ("the locus"). He was pronounced dead at that locus at 10.16 hours on Wednesday 8 July 2015.

Lamara Natalie Bell was born on 19 November 1989. She died at 06.48 hours on Sunday 12 July 2015 at the Queen Elizabeth University Hospital, Glasgow.

F2. In terms of section 26(2)(b) of the Act, when and where the accident resulting in the deaths occurred:

The accident resulting in the death of John Alexander Yuill and ultimately Lamara Natalie Bell was a single vehicle road traffic accident at the locus. The accident occurred at some time between 06.00 hours and 06.15 hours on Sunday 5 July 2015. The time period specified takes account of the time of the last sighting of the vehicle leaving Broxden Services, 2 Broxden Avenue, Perth and its final resting place at the locus.

The accident itself did not directly result in the death of Lamara Natalie Bell. It was the starting point in a chain of events, in particular the delay in recovering her from the vehicle over the course of three days, which resulted in her death.

F3. In terms of section 26(2)(c), the cause or causes of death:

The cause of death of John Alexander Yuill was head and abdominal injuries sustained in the accident.

The cause of death of Lamara Natalie Bell commenced with the head and abdominal injuries she sustained in the accident. These injuries may have been survivable had she

been rescued from the vehicle on 5 July 2015 and treatment commenced. As a result of the delay in treatment and hypothermia Lamara Natalie Bell suffered a secondary brain injury while at Queen Elizabeth University Hospital, Glasgow leading to her death. The post mortem records Lamara Natalie Bell's cause of death as: 1 (a) Complications following road traffic accident (front seat car passenger). Her death was multifactorial and set out in detail at chapter 18.

F4. In terms of section 26(2) (d), the cause or causes of any accident resulting in the deaths:

The cause of the accident resulting in the deaths of John Alexander Yuill and Lamara Natalie Bell was the failure by John Yuill to drive a motor car, vehicle registration number NU 05 LVN, with due care and attention as a consequence of which the car left the M9 motorway at the locus, crossed the hard shoulder, struck the kerb and travelled down an embankment colliding with trees before coming to rest at the foot of the embankment.

F5. In terms of section 26(2)(e), the taking of precautions which could reasonably have been taken, and, had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided:

In relation to John Alexander Yuill and Lamara Natalie Bell the following reasonable precautions could have been taken:

(a) John Alexander Yuill was the holder of a provisional driving licence. In terms of that licence he was only permitted to drive under the supervision of a suitably qualified person. On Sunday 5 July 2015 he drove the vehicle on the M9 motorway unsupervised. A reasonable precaution would have been for John Alexander Yuill not to have driven the vehicle.

(b) Having chosen to drive, a reasonable precaution would have been for John Alexander Yuill to have driven the vehicle to the minimum standards expected of a careful driver and with reasonable consideration for other road users and his passenger Lamara Natalie Bell.

(c) John Alexander Yuill was a habitual smoker of cannabis. During the evening of Saturday 4th July 2015 he smoked cannabis and drank alcohol. Having chosen to drive, a reasonable precaution would have been for him to ensure that he was in a fit and proper condition to safely do so.

In relation to Lamara Natalie Bell the following reasonable precautions could reasonably have been taken:

(a) Police Scotland to have ensured that all call handlers at Bilston Glen Service Centre, both core and non-core, were properly trained in the use of the Customer Relationship Management system ASPIRE.

(b) Police Scotland to have ensured that once trained all call handlers at Bilston Glen Service Centre, both core and non-core, operated ASPIRE at all times other than when it was not available to them.

(c) Police Scotland to have ensured that all call handlers at Bilston Glen Service Centre, both core and non-core, did not operate the telephony system AVAYA and a Pot Book when taking calls on either the 101 or 999 numbers, other than when ASPIRE was not available.

(d) Police Scotland to have ensured that the use of Pot Books by call handlers at Bilston Glen Service Centre, both core and non-core was regulated and subject to reconciliation at the end of each shift.

F6. In terms of Section 26(2)(f), defects in any system of working which contributed to the deaths or any accident resulting in the deaths, can only relate to Lamara Natalie Bell. Police Scotland's call handling procedure was a system of work. It was a defective system of work in that:

(a) Police Scotland used both core and non-core call handlers at Bilston Glen Service Centre. Non-core call handlers took calls on the 101 number only. Core call handlers took 999 calls. The call handling system of work required all call handlers to operate the ASPIRE CRM. There was no procedure in place to ensure that was so.

(b) Police Scotland's call handling system involved the use of Pot Books. There was no system in place for the regulation of their use and no system in place to ensure that entries in a Pot Book were reconciled with action taken.

F7 In terms of section 26(2)(g) there are no other matters relevant to the circumstances of the deaths.

RECOMMENDATIONS

The Sheriff having considered the information presented to the Inquiry, makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction and contents

This determination follows an inquiry into the deaths of John Alexander Yuill ("John Yuill") and Lamara Natalie Bell ("Lamara Bell"). It is made up of 37 chapters, namely:

1. Introduction
2. The Legal Framework
3. Other investigations and judicial intervention.
4. Participants and Representation
5. The Inquiry Process
6. Preliminary matters
7. The witnesses
8. John Yuill and Lamara Bell
9. What happened? – The journey to and from Loch Earn
10. Contact between the families of John Yuill and Lamara Bell and Police Scotland prior to the Missing Person's Investigation
11. The locus.
12. The John Wilson Call 1

13. The Missing Persons Investigation

14. Robert Findlay's call

15. The Emergency Services' response to Robert Findlay's call

16. The John Wilson's Call 2

17. Medical evidence and cause of death of John Yuill

18. Medical evidence, survivability and cause of death of Lamara Bell

19. The time, collision investigation and causation of the accident

20. The mechanism and cause of the accident

21. Was Lamara Bell wearing a seat belt?

22. Disposal of the blue Clio

23. Family visit to the locus and debris

24. The reform of Police Scotland's Contact, Command and Control system

25. Identified risk – Risk 6

26. Management of Risk 6

27. Systems in place at Bilston as at January 2015

28. Unidentified risks

29. The working environment at Bilston between January 2015 and July 2015

30. Assistant Chief Constable Val Thomson's return to Bilston

31. Inspector Michaela Kerr's decision to train Divisional Officers in the use of AVAYA only.

32. Training of Divisional Officers

33. Practical effect of the confused training programme

34. Brian Henry

35. Lessons learnt?

36. Submissions

37. Delay

38. Closing remarks

1. Introduction

[1] This Fatal Accident Inquiry was a discretionary inquiry under section 4 of the Act. It was held as the Lord Advocate considered the deaths of John Yuill and Lamara Bell to have occurred in circumstances giving rise to such serious public concern that it was in the public interest that an inquiry be held into their deaths. The purpose of this Inquiry was to expose publicly, what happened, why it happened and demonstrate the remedial action taken by Police Scotland and seek to restore confidence in the public's mind that Police Scotland can protect them from harm when called upon to do so.

[2] The public must, and are entitled to, have confidence in their national police force. Police Scotland exists to keep people safe. In terms of Section 32 of the Police and Fire Reform (Scotland) Act 2012 ("the 2012 Act"), its stated purpose is to improve the safety and wellbeing of people, places and communities in Scotland. The organisation acknowledges that how it delivers policing has a direct impact on the communities it serves. It acknowledges that failure to deliver effective policing undermines trust and

confidence in the communities it serves. In these objectives it failed John Yuill and to a far greater extent, Lamara Bell.

[3] This Inquiry scrutinises of the restructuring of the Contact, Command and Control Division ("C3 Division") of Police Scotland and the practices and procedures in relation to its call handling systems in general and at the Bilston Glen Area Control Room ("ACR") and Service Centre, Loanhead ("Bilston") in particular. That is necessary to understand what happened and why, but it should be remembered that this is a Fatal Accident Inquiry into the deaths of two young people and not an inquiry at large into police procedures. Accordingly this Determination addresses Police Scotland's failings only in so far as they impacted upon John Yuill and Lamara Bell.

[4] The failings of Police Scotland had fatal consequences for Lamara Bell. Her suffering over a period of three days, terribly injured but conscious, is almost incomprehensible. That suffering is compounded by the fact that she was trapped in the wreckage of a car open to the elements alongside her dead partner throughout that time.

[5] It is worth repeating the words of Lord Beckett in his sentencing statement when sentencing Police Scotland, indicted in the name of the Office of the Chief Constable of the Police Service of Scotland, following a plea of guilty by it to a breaches of the Health and Safety at Work Etc. Act 1974;

> "This case arises from terrible events in which two relatively young people died, one of them after days of severe physical suffering when she must have been in an almost unimaginable state of distress and anxiety. As the hours became days she must have felt disbelief that she could be injured and trapped in a car just off the roadway of the M9 motorway with no assistance arriving, a disbelief shared by the whole community when the full circumstances came to light.

> Both families spent days wondering what happened to cause their unexplained disappearance before learning the awful reality."

[6] Despite their deaths being almost 9 years ago that disbelief is still apparent. The circumstances of their deaths has had a corrosive effect on the public's confidence in Police Scotland. That effect was not lost on serving officers and the then Chief Constable Sir Stephen House who, on 10 July 2015, issued a public apology on behalf of his force. The opening paragraphs of that apology are worthy of repetition to underline the impact the organisation's failings had;

> "Firstly we would wish to apologise to the families of John Yuill and Lamara Bell and to the people of Scotland for this individual failure in our service. Everyone in Police Scotland feels this most profoundly.
>
> We completely understand the level of concern being raised about the circumstances surrounding the handling of the incident of the crash near the M9 slip road at Bannockburn, and in particular, Police Scotland's response to information received.
>
> That we failed both families involved is without doubt".

Notwithstanding the reference to "individual failure" this Inquiry has concluded that there was more than one and these failures took place over a lengthy period of time, during which the opportunity to resolve them was lost.

[7] At the conclusion of the prosecution of Police Scotland on 7 September 2021, the then Chief Constable, Iain Livingstone said publicly;

> "The preservation of life and helping people who are in crisis go to the heart of our duty to keep people safe.
>
> Police Scotland failed Lamara and John in that duty, and for that I am sorry.
>
> On behalf of policing in Scotland, I apologise unreservedly to their families.

When I took up the office of Chief Constable I gave a commitment that the Police Service of Scotland would cooperate fully with the Crown Office investigation into this tragedy. Police Scotland has fully participated with the inspections, investigations and enquiries established since July 2015 to identify what went wrong and safeguard against those failings being repeated in the future.

None of those investigations and enquiries change what happened or provide any consolation to the families involved but I do offer an assurance that lessons have been learned and improvements made.

The call handling system in place in 2015 exposed the public to an unacceptable risk and led to tragedy.

People are entitled to expect help when their police service tells them they will respond.

Our failure in July 2015 undoubtedly weakened the relationship of trust that exists in Scotland between policing and the communities we serve. Since that time, we have made changes to our approach which have resulted in significant improvements to reduce and mitigate risks associated with call handling across policing.

As Chief Constable, I undertake that Police Scotland will continue to fully cooperate with any other inquiries which may take place.

I reiterate my personal condolences to the families of Lamara Bell and John Yuill. I'm sorry for Police Scotland's failure to keep them safe and the tragic consequences of that failure."

[8] Throughout this Inquiry the Procurator Fiscal, with the assistance of Participants, has sought to protect Lamara Bell's dignity. In the summary of events that follows, I will strive to do likewise. However there are pieces of evidence which need to be recorded to fully appreciate the horror of her three days alone in the vehicle. They also demonstrate her level of consciousness when found. I trust that her family understand the purpose of the exercise.

[9] Police Scotland's failings did not contribute to the death of John Yuill, but they did have a considerable, detrimental effect upon his family and friends who were deeply concerned at his disappearance over a period of three days. That concern is obvious in the calls made to Police Scotland by his father, Mr Gordon Yuill. Once he and his family realised that John Yuill had lain dead in the car for a period of three days, they felt he had been stripped of dignity in death.

[10] It has taken the Crown some eight years to commence this Inquiry, an inordinate length of time. The Advocate Depute, who represented the Crown assured the Inquiry that an explanation for that delay would be offered. To that end the Crown lodged with its submissions a time-line and explanation of its investigations.

2. The Legal Framework

[11] Fatal Accident Inquiries and the procedure to be followed are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[12] In terms of section 1(3) of the Act the purpose of an inquiry is to (a) establish the circumstances of the deaths and (b) consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances.

[13] Section 26 of the Act requires the Sheriff to make a Determination. In terms of section 26(2), the Determination must set out the factors relevant to the circumstances of the death, in so far as they have been established. These are: (a) when and where the death occurred; (b) when and where the accident resulting in the deaths occurred; (c) the

cause or causes of such death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of working which contributed to the deaths or any accident resulting in the deaths and (g) any other facts which are relevant to the circumstances of the deaths.

[14] In terms of section 26 subsections (1) (b) and (4) of the Act the inquiry may make such recommendations, if any, as the Sheriff considers appropriate as to: (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstance.

[15] Recommendations may, but need not, be addressed to (i) a participant in the inquiry or (ii) a body or office-holder appearing to the Sheriff to have an interest in the prevention of deaths in similar circumstances.

[16] In order to identify a precaution which, if taken, might realistically have avoided the accident or deaths it is not necessary to conclude that the precaution would in fact have avoided the accident or death, but that it might have. The test is one of possibility rather than probability, but the possibility must be real rather than remote or fanciful. The test is determined on the balance of probabilities.

[17] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding Sheriff must make a Determination setting out findings and recommendations, if any, as the Sheriff considers appropriate.

[18] The inquiry proceeds on the basis of evidence placed before it by the Procurator Fiscal and by the parties to it. The Determination must be based only on the evidence presented. The Determination is limited to the matters defined in section 26 of the Act.

[19] Section 26(6) of the Act provides that the Determination shall not be admissible in evidence or be founded on in judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death.

[20] It is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability. However in this Inquiry, criminal liability was established in the prosecution and conviction of the Office of the Chief Constable of Scotland for its failings in relation to the deaths of John Yuill and Lamara Bell. The Crown did not prosecute any individual. From the outset, the Crown contends that the "M9 incident" occurred due to the failings of the Office of the Chief Constable of Scotland. While individual failings are apparent, the Crown did not invite the Inquiry to express blame or attribute fault to them. All civil claims arising out of these failings have been settled extra-judicially.

[21] Ordinarily the Inquiry is not simply a fact finding exercise. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where, as here, the circumstances give cause for serious public concern an Inquiry may serve to restore public confidence and allay public anxiety. A large part of this Determination is the setting out of agreed facts. There was little dispute to be resolved. Whether or not Lamara Bell would have survived had she been rescued within hours of the accident was anticipated to be the most significant area of dispute. As it transpired that issue became a matter of agreement.

[22] Section 14 (1) (b) of the Act allows a single Inquiry to be held into the deaths of more than one person if it appears to the Lord Advocate that the deaths occurred as a result of the same accident. That is so in this Inquiry.

3. Other investigations and judicial interventions

[23] In the eight years that it has taken to get to this Inquiry there have been a number of investigations, and a prosecution that have scrutinised in considerable detail, the failings on the part of Police Scotland. The most important of which are as follows:

The Police Investigations & Review Commissioner

[24] The role and function of the Police Investigations & Review Commissioner ("PIRC") is set out in the 2012 Act. The Commissioner is appointed by Scottish Ministers. The Commissioner is independent of Police Scotland. The role of PIRC is to provide an independent oversight of, and investigate incidents involving Police Scotland. Its stated aim is to secure public confidence in policing in Scotland.

[25] On 9 and 13 July 2015 the Lord Advocate instructed PIRC to investigate the circumstances surrounding the deaths of John Yuill and Lamara Bell. The Lord Advocate did so in terms of section 33A of the Police, Public Order and Criminal Justice (Scotland) Act 2006. The instruction was to investigate firstly, the circumstances surrounding a call made by Mr John Wilson to Police Scotland on 5 July 2015 ("John Wilson Call 1") and why it was not followed up and secondly the efficacy of the Missing Persons Inquiry ("MISPER") conducted by Police Scotland. PIRC issued an

interim report (Operation Arkaig) in November 2015 and a supplementary report in June 2016.

[26] PIRC did not publish these reports. The Crown made both reports available to their expert witness, Mr Roderic Sylvester-Evans, an unusual step as PIRC reports are not as a matter of routine disclosed.

Her Majesty's Inspectorate of Constabulary in Scotland.

[27] Her Majesty's Inspectorate of Constabulary in Scotland ("HMICS") is an independent body charged with scrutiny of Police Scotland. The 2012 Act empowered HMICS to look into the state, effectiveness and efficiency of both Police Scotland and the Scottish Police Authority ("SPA"). The Scottish Ministers can direct HMICS to look into anything relating to Police Scotland. When undertaking an investigation the Chief Constable must co-operate and assist that investigation and comply with any reasonable requests made by HMICS. On completion of an investigation HMICS may publish a report and may make recommendations to Police Scotland to improve policing. Where such recommendations are made, HMICS will follow them up and report publicly on progress. The purpose of this independent scrutiny and evidence led reporting is designed to strengthen public confidence in Scottish policing.

[28] Following the deaths of John Yuill and Lamara Bell, the then Cabinet Secretary for Justice directed HMICS to conduct an assurance review. The focus of the review was to provide an independent assessment of the operation, systems and procedures in place in Police Scotland Contact, Command and Control centres across Scotland. An interim

report was produced in September 2015. A full report was produced in November 2015, updated in January 2017 and May 2018. A Briefing Note was produced in September 2021 and a further report published in August 2022. HMIC published these reports.

Status of the PIRC and HMICS reports

[29] The PIRC and HMICS reports are available to the Inquiry and referred to in Joint Minute number 1. They are reports prepared by an external agency in exercise of their statutory powers. They have been referred to throughout the Inquiry without objection. No evidence or contrary reports have been produced to contradict them. They have been of considerable assistance to the participants and the Inquiry.

Crown Office investigation and prosecution of Police Scotland

[30] Following a Crown Office investigation, Police Scotland was prosecuted for its failings in relation to the deaths of John Yuill and Lamara Bell. On 7 September 2021, it pled guilty to a s76 Indictment in the High Court of Justiciary to a contravention of the Health and Safety at Work etc. Act 1974, sections 3(1) and 33(1) (a). The Chief Constable admitted, *inter alia,* that Police Scotland failed to ensure that its call handling system was not vulnerable to risk from human error and that it failed to ensure that all relevant information reported to it by members of the public requiring a police response was recorded. As a consequence of these failings members of the public were exposed to risk. The Indictment specified that on 5 July 2015 the failure to record and action a call led to John Yuill and Lamara Bell, being left unaided between 5 and 8 July 2015 which

materially contributed to the death of Lamara Bell. Following a plea-in-mitigation the court imposed a fine of £100,000.

Independent report by Roderic Sylvester-Evans

[31] The Crown Office instructed Roderic Sylvester-Evans of RSE Consultants Limited, a company specialising in accident investigation and safety and risk management to prepare an independent opinion on the restructuring of the call handling of Police Scotland and risk management matters arising from it. Mr Sylvester-Evans' credentials are impeccable and were not subject to challenge. His report dated 2 8 February 2020 is a matter of agreement.

4. Participants and representation

[32] The Procurator Fiscal represents the public interest in a Fatal Accident Inquiry. In this Inquiry, the Procurator Fiscal was represented by Gavin Anderson, KC and Elaine Smith, Advocate.

[33] The family of John Yuill was represented by Brian McConnachie, KC and Laura Anne Radcliffe, Advocate. The family of Lamara Bell were represented by Andrew Brown, KC and Lily Prais, Advocate. Brian Henry was represented by Duncan Hamilton, KC. Shelagh McCall, KC and Christopher Miller, Advocate represented Chief Superintendent Craig Naylor, former Superintendent Jill Harper, Superintendent David Tonks and Assistant Chief Constable Alan Speirs. Carla Fraser, Advocate and Robert Vaughan, Solicitor Advocate represented former Police Inspector Michaela Kerr. Ray

Gribben, Solicitor Advocate represented former Assistant Chief Constable Val Thomson. Murdo MacLeod, KC and David Adams, Advocate represented the Police Service of Scotland. Amber Galbraith, KC and Emma Toner, Advocate represented HMICS.

5. The Inquiry process

[34] A Notice of an Inquiry was given by the Procurator Fiscal under section 15(1) of the Act on 19th October 2022. The First Order assigned a Preliminary Hearing for 16th December 2022 in Stirling Sheriff Court. At the Preliminary Hearing on 2 8 April 2023, I made an order in terms of section 4 (2) of the Contempt of Court Act 1981 and schedule 4 paragraphs 4 to 7 of the Rules prohibiting the publication of details which might identify persons who made contact with Police Scotland other than in relation to the accident or the resulting MISPER. At the Preliminary Hearing on 27 June 2023, I granted the Procurator Fiscal's application in terms of Rule 4.2(b). At the final Preliminary Hearing, Joint Minute number 1 was lodged. That Joint Minute runs to 79 pages and 326 paragraphs. Joint Minutes 2-6, were lodged as the Inquiry progressed. Without these Joint Minutes this Inquiry may well have taken up to eight weeks to conclude including two weeks of expert medical and scientific evidence.

[35] Other Preliminary Hearings took place conform to the interlocutors published on the dedicated SCTS website. The Preliminary Hearings were a very useful management tool and served to ensure that when the Inquiry started it ran as smoothly as it did.

6. Preliminary matters

[36] Before setting out a summary of the evidence, I set out my approach in constructing my Determination.

[37] The circumstances surrounding the deaths of John Yuill and Lamara Bell occurred more than eight years ago. It is clear from the other investigations, set out at Chapter 3, that fault has been exposed. There is no need for me to search for fault. While it is not the purpose of this, or for that matter any other FAI to establish fault, it is my responsibility to record it. To do otherwise would fail to achieve the whole object of the Inquiry, namely to get to the truth.

[38] The conclusions that the other investigations reached are not a matter of dispute. The various reports are productions and available to those minded to read them.

[39] Formal Findings in Fact are not mandatory in a FAI. What is required in terms of Rule 6.1 is that the Determination sets out the facts. I intend to set out the facts established in summary form rather than to rehearse the minutiae of the extensive evidence available to the Inquiry in the form of Findings in Fact.

Summary

[40] This summary is drawn from the six joint minutes of agreement, the witnesses' written statements in terms of the Rule 4.2 (b) order, the oral evidence, productions, labels and the reports referred to at Chapter 3. Where there were discrepancies in the evidence, significant to my findings, I have addressed these when considering the issues before the Inquiry. I have sought to deal with the participants submissions at the

relevant part of the summary but were that is not possible I have dealt with them at the conclusion of it.

7. The witnesses

[41] The Inquiry commenced on Monday 1 8 August 2023, with the reading of Joint Minute of Agreement number 1. In terms of Joint Minute number 1, the statements of all witnesses on the Crown list are treated as the equivalent of signed manuscript statements and available to the Inquiry. Thereafter the Crown led the following witnesses in evidence:

1. Gordon Yuill, the father of John Yuill
2. Liam Bell, the brother of Lamara Bell
3. John Wilson
4. Chief Inspector Mandy Paterson, Police Scotland
5. Superintendent David Reid, Police Scotland
6. Robert Findlay
7. Watch Manager Craig O'Donnell, Scottish Fire and Rescue
8. Iain Lockhart, Fire Fighter, Scottish Fire and Rescue Service
9. James Stewart, Area Service Manager, the Scottish Ambulance Service
10. Sergeant Ruth Aitchison, Police Scotland
11. Richard Vallance, Forensic Scientist, SPA
12. Inspector Andrew Thompson, Police Scotland
13. Michael McCormick, retired Assistant Chief Constable, Police Scotland

14. Val Thomson, retired Assistant Chief Constable, Police Scotland
15. Laura Henderson, Service Centre Manager at Bilston Glen Service Centre
16. Michaela Kerr, retired Police Inspector, Police Scotland
17. Brian Henry, retired Police Sergeant, Police Scotland
18. Mark Hargreaves, Assistant Inspector of Constabulary, HMICS
19. Chief Superintendent Paul Wilson, Police Scotland

[42] I found all the witnesses to be, by and large, credible and reliable. Where I have any concerns as to a witnesses credibility or reliability that will be reflected in the appropriate section of this Determination.

[43] The reliability of some of the witnesses was impacted by the delay of 8 years between the accident and the commencement of the Inquiry. Even professional witnesses, police officers of all ranks, who provided statements around the time of the accident and were referred to them during the course of their evidence were, at times, unable to recall matters not contained within the four walls of their statements.

8. John Yuill and Lamara Bell

[44] John Yuill was 28 years old at the date of his death, having been born on 8 August 1986. He lived in Falkirk. He was the only son of Gordon Yuill and Jacqueline Forsyth, his biological mother. Anita Dollard, his father's partner, took on the role of mother to him. He referred to her as "Mum". He had three sisters and three brothers. He was a director, along with his father, in a family business specialising in processing caravans for their re-useable parts. He has a nine-year old daughter from his

relationship with Lamara Bell. He was only made aware that he was the child's father in the weeks prior to his death. At the date of his death he had four other children, ranging from 13 weeks to nine years of age, from three previous relationships. He maintained contact with three of his children. He was considered a good father and family man.

[45] John Yuill was a social drinker, drinking modestly at the weekend. He was a habitual user of cannabis. He smoked cannabis from the age of 14. According to his father, he smoked in the order of 30 cannabis cigarettes ("joints") per day. Shortly before his death he consulted with his G.P to address his cannabis consumption. As a consequence of his cannabis consumption, he suffered bouts of paranoia and depression. He was not medicated for these ailments. He never exhibited suicidal tendencies. I stress that because there is an erroneous reference to that in the productions.

[46] Lamara Bell was 25 years of age when she died, having been born on 19 November 1989. She was the only daughter of Andrew Alan Bell and Diane Elizabeth Bell. She lived in Falkirk. She had two brothers and one sister. In addition to her daughter with John Yuill, she had one other child from a previous relationship. Lamara Bell was considered a good mother with strong family ties. She was humorous, known to drink socially and to smoke cannabis. She suffered from bouts of anxiety and depression for which she was prescribed Citalopram. She had never exhibited suicidal tendencies.

9. What Happened? – The journey to and from Loch Earn

[47] On Saturday 4th July 2015, John Yuill and Lamara Bell along with her brother Liam Bell, Lauren Mackay and Paul Mooney set off from Falkirk on a wild camping trip to Loch Earn.

[48] They travelled together in John Yuill's blue Renault Clio, registration number NU 05 LVN (the blue Clio). It was purchased by John Yuill from his sister Kara Yuill. Notwithstanding the purchase, as at 5 July 2015, the registered keeper on the DVLA database remained Kara Yuill.

[49] John Yuill held a provisional driving licence, first issued in July 2010. He was reissued his provisional licence on 19th June 2015. He drove the car to Loch Earn under the supervision of Paul Mooney, who held a full licence. Lamara Bell did not hold a driving licence.

[50] Although he never passed a driving test John Yuill had been driving, on a regular basis, since the age of 17. He was an experienced driver. His father's one criticism of his son's driving was that he was prone to driving too fast on motorways. He described him as a "*boy racer*". He had been in a car with him when he drove at between 90 - 100mph. He did not like the experience and told him to slow down. He said Lamara Bell enjoyed the experience of speeding when with John Yuill in the blue Clio.

[51] John Yuill and Paul Mooney knew the routes from Falkirk to Loch Earn well. Between 2014 and 2015 they travelled there on a daily basis for business purposes. They used two routes. Route one took them through Stirling to Callander and then Loch

Earn. Route two was via the A9 onto Greenloaning through Braco, Comrie and onto Loch Earn. His father said John Yuill knew these routes and the surrounding area like the back of his hand. He was familiar with the motorway network around the central belt and the locus.

[52] The group arrived at Loch Earn at around 21.00 hrs. On arrival they pitched a tent, built a camp fire and spent the rest of the evening socialising. John Yuill, Lamara Bell and Paul Mooney drank alcohol. John Yuill, Lamara Bell and Liam Bell smoked cannabis.

[53] Sometime around 22.30 - 23.00 hrs Liam Bell and Lauren Mackay left the group and entered the tent. John Yuill became upset over a trivial matter and argued with Paul Mooney and Lamara Bell. At some point he left the others and got into the blue Clio. A little later Lamara Bell followed him in.

[54] At around 01. 20 hrs on Sunday 5 July 2015 Lauren MacKay woke to the sound of music coming from the blue Clio. She heard John Yuill say that he was going home and the car engine start up. When the engine started she heard Lamara Bell shout John Yuill's name in a warning of some sort and the engine was switched off. The music continued. At some point thereafter, the precise time being unknown, the blue Clio left the campsite. The blue Clio was driven by John Yuill. Lamara Bell was a passenger. The rest of the group were unaware of their departure, until they awoke in the morning.

[55] At around 08.50 on Sunday 5 July 2015 Lauren Mackay, Liam Bell and Paul Mooney discovered John Yuill, Lamara Bell and the blue Clio gone. Lamara Bell left her mobile phone and foot wear behind. Paul Mooney's mobile phone was in his

jacket which was in the blue Clio. Attempts were made to contact the mobile phones belonging to John Yuill and Paul Mooney. These attempts failed as both phones were switched off.

[56] Liam Bell phoned his mother, Diane Bell, and told her that he and the others were stranded at the campsite. Diane Bell and her husband, Andrew, agreed to collect them.

[57] Between leaving the campsite and the locus, three pieces of information disclose the blue Clio's journey and identifies timings:

1. At around 05.31 hrs on Sunday 5 July 2015 the blue Clio was captured by a speed camera travelling north on the A9 between its junction with an unclassified road leading to Tibbermore and the Broxden roundabout at Perth.
2. At 05.40 hrs the blue Clio was captured on CCTV entering the forecourt at the Broxden Service Station, Perth ("Broxden"). Both John Yuill and Lamara Bell were captured on the service station's CCTV in the shop. Both are seen leaving the shop and John Yuill drives the blue Clio from the forecourt with Lamara Bell in the passenger seat.
3. Cell site analysis disclosed that at around 05.50 John Yuill's work phone made contact with a telephone mast situated at Longfauld Farm, Blackford.

10. Contact between the families of John Yuill and Lamara Bell and Police Scotland prior to the Missing Person's Inquiry

[58] At around 4pm on Sunday 5 July 2015, Gordon Yuill was visited by Paul Mooney, Lauren McKay and Liam Bell. They asked if he had heard from John or Lamara. He said he had not and Paul Mooney told him what had happened at Loch Earn. This caused Gordon Yuill concern. It was out of character for his son not to be in touch. He phoned John Yuill's mobile and left a message asking him to contact him. He checked his son's Facebook page and noted that he was last on it, by his calculations, between 06.00 and 07.00 hours that day. As the day progressed and nothing was heard from either John Yuill or Lamara Bell, their families became increasingly anxious for their safety. Lamara Bell had an important meeting concerning the welfare of her children on Monday 6th July 2015 and was determined to attend. Her children were being looked after while she was camping and due to be returned to her on Sunday. No one expected her not to return in good time.

[59] On Sunday 5 July 2015 at 16.40 hours Gordon Yuill called Police Scotland, using the 101 system, to ask if his son was in custody. He was advised that no one by that name was in custody in either Falkirk or Stirling.

[60] At 17.49, same date, Diane Bell called Police Scotland on 101 to find out if Lamara Bell was in custody. She was connected to the Falkirk Custody Office. It was confirmed that she was not. She asked to report her daughter as a missing person. She was told to redial and choose another option from the menu offered. Redialling was

unnecessary as the call handler could, and should, have dealt with her request at that stage. She did not call back that day.

[61] At 21.30 hrs, same date, Gordon Yuill called Police Scotland on 101. He was connected to Bilston. He again asked if his son was in police custody. It was confirmed that he was not and he formally reported him as a missing person. He advised the police that he was last seen in the company of Lamara Bell.

[62] Following that call, Police Scotland commenced a MISPER. Although at that stage they did not have a formal report of Lamara Bell as a missing person, because John Yuill was last seen in her company, Police Scotland deemed her so for the purposes of the investigation.

[63] At 22.14 hours, same date, Gordon Yuill called 101 and was connected to Bilston. He informed the call-handler that his son may be in custody in Stirling as he had seen the name "*John Yuill*" on the SCTS website. It was confirmed that he was not.

[64] At 07.23 hrs on Monday 6th July 2015 Diane Bell called Police Scotland on 101 and spoke with a custody Sergeant who confirmed that Lamara Bell was not in police custody. She reported Lamara Bell as a missing person. That was the first formal report of Lamara Bell as a missing person.

[65] Throughout the night of Sunday 5 July and the morning of Monday 6th July 2015, police officers attempted to contact Diane Bell, without success, as part of the MISPER.

11. The locus

[66] The locus of the accident is specified as the M9 Edinburgh to Perth motorway eastbound, junction 10 to junction 9 at a point 125 meters southeast of the New Line Road Overbridge, Bannockburn near to where the M80 Stirling to Glasgow motorway begins.

[67] The M9 is four lane motorway consisting of two lanes running generally North West and South East. These lanes are separated by a central reservation comprising a cable barrier on stone drainage chips. The national speed limit of 70mph applies.

[68] Prior to leaving the carriageway, the blue Clio was travelling on the South East bound M9 carriageway. A divergence between the M9 and the M80 motorways ("the Divergence") begins approximately 30 meters before where the New Line Road Overbridge ("the Flyover") crosses the M9. From the Divergence the M9 continues in an easterly direction. The M80 takes traffic south.

[69] Motorists approaching the Divergence from the South East are alerted to it in a number of ways. There are 2/3 and 1/3 mile, advance direction signs. Direction arrow road markings are on lane 1 of the M9 at the start of the Divergence, 30 meters before the Flyover. Overhead, or gantry, direction signs are located on the north side of the Flyover. A broken white line of short gaps separates the M9 and M80 motorways and at the Divergence there is an area of white chevrons.

[70] Other than the chevrons, which were found to be in a poor state of repair and not immediately visible, all other lane markings and signage were good condition.

[71] The M9 at the locus is bordered by a hard shoulder. Beyond the hard shoulder is a grass verge separated from it by a low, angled kerb. The grass verge is approximately 3 meters wide. The grass verge gives way to an embankment. The embankment is measured at a 24 degree angle from top to bottom. The drop from top to bottom of the embankment is 4.3 meters. The area between grass verge and the foot of the embankment contains mature evergreen trees. At the foot of the embankment lies a relatively flat strip of land, approximately 4 meters wide. Heavy undergrowth, weeds, wild plants and debris cover this area. This is where the blue Clio was ultimately found.

[72] The strip of land at the foot of the embankment is separated from a field of arable land by a boundary fence. The boundary fence is constructed with 1.5 meter high wooden poles set 2 metres apart with four equally spaced horizontal wooden rails. The fence was covered in vegetation screening the foot of the embankment from the arable land. The field leads across to another steep embankment. At the top of that embankment is Pirnhall Road, Bannockburn. Pirnhall Road is bounded by mature trees. There are gaps in the tree line that allow a view of the area where the blue Clio was found. It is from Pirnhall Road that both John Wilson and Robert Findlay first saw the blue Clio.

12. The John Wilson Call 1

[73] John Wilson is a farmer and farms land around the locus. He holds a full driving licence and is the holder of a Class 1 HGV licence.

[74] On Sunday 5 July 2015 at around 10.00 - 10.15 hrs John Wilson and his father were travelling along Pirnhall Road. Pirnhall Road runs parallel to the locus. He was travelling towards the Flyover. His father alerted him to a blue vehicle lying at the locus. Mr Wilson, stopped his vehicle to have a closer look. He saw a small metallic blue car at the bottom of the embankment. It was partly hidden by trees, bushes and the fence. He was unable to see the make or model of the car or its registration. He observed the car for a while and saw no one at or around it. He came to the conclusion that the car probably came off the road in the last 24 hours. There had been a thunderstorm in the area the night before but by morning the roads were dry. He was in no position to approach the vehicle. It was down the steep embankment and bordered by the M9. There was no blue and white *"police aware"* tape on it.

[75] At 11.28 hours on Sunday 5 July 2015 John Wilson telephoned Police Scotland using the 101 system. He was connected to Police Sergeant Brian Henry who was working as a call handler at Bilston. That call is referred to as the John Wilson Call 1. It is a crucial element of this inquiry and I set it out verbatim:

BH - Good morning you are through to Police Scotland, how can I help you?

JW – Ah, yes ah John Wilson speaking, I'd like to report the car that's went off the road eh on the M9 sterling… Perth/Stirling Road.

BH – Okay right okay has it just happened?

JW – Well, I hopefully think not eh.

BH – Is there anyone with the vehicle just now?

JW – No no.

BH – It may well be that we have a report of this but I'll take some details.

JW – It's just there was no kinda police tape or anything like that.

BH – Normally yeah we tend to put up a notice up to say we are aware of it.

Emm okay. Do you know which junction you are near?

JW – Yep eh…. It will be junction 9 of the M9.

BH – I wasn't on the north of the southbound carriageway?

JW – Southbound carriageway just as yae…. Just as the fork splits for Edinburgh/Glasgow.

BH –Aaw right I think I know where you are.

JW – After the Long Wynd flyover bridge.

BH – Yep, so it is definitely the M9 we are talking about.

JW – Yes, that's yep.

BH – Perth to Stirling and what kind of vehicle was it?

JW – I dunno what kind of vehicle but it's a kinda blue colour, it's hidden in trees and bushes

BH – Okay, emm would you like to leave your name? Its John Wilson is it?

JW – Yes, aye

BH – Emm. I've got a mobile number, have you returned home

JW – Aye yeah.

BH –Emm what's your address Mr Wilson?

JW – Chattershall Farm in Stirling.

BH – Churchhill farm?

JW – Yeah… It may have happened yesterday morning but jist as I say… I didnae see any blue tape… No tape

BH – It didn't look like there was anybody near it.. It looked like it had happened previously. I'll check back our jobs to see if there's anything been reported and if not we will get it checked out anyway. That's great thanks for phoning, in just in case that is anything amiss with it.

JW – Right that will do fine then ok.

BH – That'll dae fine for us. Thanks for your call

[76] Mr Wilson accurately reported the location of the vehicle and its colour. He reported no police tape around the vehicle. He was unable to say whether or not it appeared to be a recent accident and comments that it may have happened the day before. Brian Henry assured John Wilson that his call would be acted upon, and that he would check for any other reports which matched Mr Wilson's.

[77] John Wilson assumed, as he was entitled to do, that the police would check the vehicle or have other agencies do so.

[78] On Monday 6th July 2015 at around 09.30 hours, John Wilson was travelling home in his lorry, along the M9, southbound. As he approached the locus he was looking for evidence as to why the vehicle may have gone off the road. He observed skid marks veering to the left of the carriageway. He described the skid marks as "*readable*" and giving him the impression that a vehicle had turned too fast and too sharp. He formed the view that a driver tried to take the Edinburgh road from the Glasgow road, but too late. He could see that the tree line had been disturbed and trees damaged where the car

had gone down the embankment. He was unable to see the blue Clio from the roadway. On Tuesday 7 July 2015, Mr Wilson noticed that the car was still at the foot of the embankment.

13. The Missing Persons Investigation

[79] Gordon Yuill formally reported his son as a missing person on Sunday 5 July 2015 at 21.32 hours. Police Scotland commenced a MISPER. As John Yuill was reported as "last seen" in the company of Lamara Bell, Police Scotland deemed her a missing person for the purposes of the investigation, an important decision made at a very early stage of the MISPER. It is unusual for two people to disappear together at the same time. That they had done so voluntarily could not be discounted, but it was thought more likely that their disappearance was as a result of an accident, illness or injury. That hypothesis directed the MISPER from the outset. As the investigation developed, the working hypothesis was that the car had left the road at some point after leaving the campsite.

[80] The MISPER proved fruitless, in the sense that the blue Clio was discovered by Robert Findlay before it concluded. It is appropriate to set out how Police Scotland conducted the MISPER and its timeline. The purpose of this exercise is to consider the efficacy of the MISPER and what, if any, lessons have been learnt for future MISPERs.

[81] Those leading the MISPER were unaware of the John Wilson Call 1. They were conducting a MISPER into the disappearance of two people last seen at an unofficial, or wild, camp site at Loch Earn on Sunday 5 July 2015 before leaving at some time in the

early hours of that morning. Where they were headed was unknown, but it would have been a reasonable to assume that it was, one way or another, home to Falkirk. Even with that knowledge there are a number of ways to reach Falkirk from the campsite and there are many side roads, rural roads, farm roads and forestry tracks leading from the main roads. The Police found the area around Loch Earn a challenging search.

[82] The conduct of a MISPER is governed by the *Police Scotland Standard Operating Procedure (v.5.00).* The version in force at the time of this investigation was published on 9th April 2015.

[83] In terms of the SOP a "*missing person*" is defined as:

(i) Anyone whose whereabouts are unknown and the circumstances are out of character, or,

(ii) The context suggests that the person may be the subject of a crime, or

(iii) The person is at risk of harm to themselves or others.

[84] Once someone is designed a missing person, they remain so until located and their circumstances identified.

[85] The following aspects of the SOP are pertinent in assessing the effectiveness of this MISPER:

(i) At all levels, early and effective command and control is vital. The initial supervision of the MISPER is the responsibility of the Sergeant. The Sergeant is required to be proactive in risk assessment and general control of the investigation.

(ii) The assessment of risk must be kept under constant review. In a High Risk MISPER an escalation in the chain of command is mandatory.

(iii) The Inspector must escalate the chain of command in the event that it develops into a critical incident. It is common practice for a MISPER to be managed by an Inspector over the first 24 hours regardless of the risk grading.

(iv) The Inspector must ensure that the Local Area Commander is briefed on any MISPER prior to the daily Local Tasking and Coordinating meetings.

(v) A Missing Persons Investigation Form must be created and record all actions taken in the investigation.

(vi) In High Risk MISPER the Inspector must ensure early contact with specially trained Police Search Advisors ("POLSA"), CID officers, Telecom and Cybercrime units and that all other specialist resources are considered for tasking.

(vii) In High Risk cases consideration must be given to an early media release.

(viii) Consideration must be given to the use of outside/partner agencies. In this MISPER the relevant social work department were informed of Lamara Bell's status as a missing person.

[86] In terms of the SOP once a MISPER commences, a risk assessment must be carried out to categorise the missing person. There are three categories of risk, Low, Medium and High. High Risk is defined as, amongst other things, there being substantial grounds for believing that the missing person is in danger through their own

vulnerability and the risk posed is immediate. Very quickly into the investigation John Yuill and Lamara Bell were considered High Risk missing persons.

[87] The SOP carefully details the roles and responsibilities of those involved in the investigation from the moment a person is reported as missing. The SOP stipulates that the investigation must be meticulous, dynamic and kept under constant review. The records of the MISPER are subject to the same stringent requirements.

[88] From the outset, a single point of contact ("SPOC") should be provided for the family of the missing person. That enables the family to provide and receive information on the progress of the investigation. Sergeant Alasdair Goldie was appointed SPOC. Sergeant Goldie had previous experience of supervising High risk MISPERs.

[89] In terms of paragraph 12.4 of the SOP, unless there are specific reasons not to, the initial searches are to be conducted at the place that the missing persons were last seen, the place missing from and the home address. Searches should include grounds, outbuildings and surrounding areas. Until well into the MISPER, John Yuill and Lamara Bell were "last seen" at the campsite at Loch Earn.

[90] In terms of paragraph 12.8 of the SOP, locations frequented and routes that may have been taken by the missing persons should be considered for search to include areas adjacent to or near these routes.

[91] The MISPER is further governed by the *Missing Person Intelligence Strategy* which instructs the inquiry team to use all available intelligence gathering techniques and systems effectively to:

(i) Identify the missing person's lifestyle.

(ii) Identify the missing person's family connections.

(iii) Identify current and historical locations frequented by the missing person.

(iv) Identify any current and known associates of the missing person.

(v) Identify the missing person's financial position.

(vi) Identify any potential threat, risk or harm which the missing person may be exposed to, and Secure the safe return of the missing person as soon as possible.

[92] Further guidance in the conduct of a MISPER is provided in terms of the *Practical Advice on Search Management and Procedures (ACPO) 2006.* That document outlines an eight stage process designed to ensure that the objectives of any MISPER are achieved, and speculative searching is avoided. That eight stage process is SCENARIO based searching, an acronym for the following stages:

S - Specify what is being sought

C - Confirm last location

E - Establish circumstances of disappearance

N - Note factors influencing discovery

A – Analyse possible scenarios

R – Raise search strategies

I – Identify priority search

O – Ongoing re-assessment

[93] Each police officer involved in the investigation is armed with a MISPER *Aide Memoire.* The *Aide Memoire* sets out the aims of the investigation. It is important that all and any factors leading or contributing to a disappearance are understood by all officers involved in the investigation.

[94] The conduct of a MISPER requires to be tightly controlled and documented and an appropriate chain of command established from the moment a report is made.

[95] The initial stages of this MISPER were undertaken by PC Dee Marshall. Commencing around 22.45 hours on Sunday 5 July 2015, PC Marshall confirmed with colleagues in Stirling and Falkirk that neither John Yuill nor Lamara Bell were in custody. A check with Forth Valley Hospital also proved negative.

[96] PC Marshall obtained John Yuill's mobile phone number, and at around 23.00 hours, she called that number. It went straight to voicemail. She left a message asking him to contact her, telling him he had been reported as a missing person. She obtained a mobile number for Lamara Bell and telephoned her. Her call was answered by Lauren McKay.

[97] PC Marshall ascertained from the Police National Computer ("PNC") that the blue Clio was registered to Kara Yuill.

[98] On Monday 6th July 2015, PC Marshall instructed a "*marker*" be placed on the blue Clio. The marker was placed on the PNC at around 09.48 hours. The marker reads; *"Low stop details check driver/occupant details maybe MISPER. Maybe travelling in this vehicle"*.

[99] At around 00.16 hours on Monday 6th July 2015 PC Marshal attended the home of Gordon Yuill and took statements from him and Paul Mooney. Thereafter John Yuill's home and business addresses and Lamara Bell's home address were searched.

[100] PC James McKerl sent e-mails to colleagues in other police divisions providing details of the MISPER and requested checks and searches be carried out. He created a Single Incident Log at 01.45 hours on Monday 6th July 2015. That log details searches carried out by colleagues in other forces, including, by way of example, searches of the Grand Eagles Caravan Park at Auchterarder, a street by street search of Auchterarder, Gleneagles railway Station, Muthil, Braco and Greenloaning. The searches included unclassified roads in and around the various locations.

[101] On Sunday 5 July 2015 Inspector Ralph Maxwell commenced duty at 23.00 hours. He was briefed by the duty Sergeant on the progress of the MISPER. Based on the early information, the initial risk assessment was Medium. As the investigation progressed Inspector Maxwell raised the risk to High due to the following factors:

(i) John Yuill did not hold a full driving licence.

(ii) John Yuill and Lamara Bell had smoked cannabis and drank alcohol at the camp site.

(iii) John Yuill had a verbal altercation with Lamara Bell and others, and

(iv) That initial inquiries discovered no trace of him, Lamara Bell or the blue Clio.

[102] At around 05.30 hours on Monday 6th July 2015 Inspector Maxwell sought and was granted authority in terms of the *Regulation of Investigatory Powers Act 2000* to obtain telecommunication data on John Yuill's mobile phones.

[103] On Monday 6th July 2015, Police Scotland's Communications Investigation Unit at Gartcosh, interrogated John Yuill's mobile phones. Live trace telecom data showed that his personal phone was last connected to a network on Saturday 4th July 2015 at 23.00 at Loch Earn. His work phone was last connected to a network on Sunday 5 July 2015 at 05.50 hours and activated a mast at Longhauld Farm, Blackford. That gave the location of the mast and the direction of the call. No further activity was detected on the phone after that date and time.

[104] The Blackford mast was assessed as having an approximate radius or cell range of 11.4km. Mapping of the data was carried out at Gartcosh and a map provided to Inspector Maxwell. Mapping based on mobile phone activation is not definitive but indicative of locations. Inspector Maxwell thought the mapping indicated that John Yuill had travelled eastwards towards Crieff and possibly on minor roads towards Braco. He knew, from his previous experience in the Road Policing Unit, the area to be rural, and potentially dangerous.

[105] At 07.00 hours on Monday 6th July 2015, Inspector David Reid assumed operational lead for the MISPER, and was briefed by Inspector Maxwell on its progress. At 07.30 hours he requested the Operational Support Division carry out an aerial search of the area mapped. A search was conducted, by helicopter, of an area north of Greenloaning to Drummond Castle between Crieff and Auchterarder spreading east of

Auchterarder and south of Gleneagles. Later, on the same date, a search of the south side of Loch Earn and the road leading into Auchterarder was conducted from the air

[106] The A9 south from Perth to the Keir Roundabout at Dunblane and roads around the Loch Earn campsite were searched.

[107] At 07.00 hours on Monday 6th July 2015 Chief Inspector Mandy Paterson, Area Commander at Falkirk commenced duty. As Area Commander she chaired the morning Local Area Tasking meeting and attended the daily Divisional Tasking meeting. Incidents of note were considered at each. On starting her shift she was briefed on the progress of the MISPER. Inspector Maxwell informed her that, from his knowledge of the road network from the campsite to Falkirk, John Yuill and Lamara Bell may have come to harm and that the vehicle may have left the road. POLSA officers formed the same view. This information along with the telecom data determined the search strategy.

[108] At 09.00 hours, Monday 6th July 2015, CI Paterson chaired the Local Area Tasking meeting. She appointed Inspector David Reid as operational lead for the current shift supported by Inspector William Drummond. CI Paterson scheduled a case conference for 12.00 hours and requested the attendance of CID, POLSA, and a representative from D Division. The last sighting of John Yuill and Lamara Bell was in D Division

[109] At 09.30 hours on Monday 6th July 2015, Chief Superintendent John Hawkins chaired a Tasking Mission. CI Paterson briefed the senior management team on the progress of the MISPER. Fearing fatalities, a Gold Group was established. Superintendent Stephen McAllister was appointed Gold Commander, CI Paterson was

appointed Silver Commander and Inspector Reid appointed Bronze Commander. As Bronze Commander, Inspector Reid was Operational Lead providing direction and operational control over the MISPER. The Bronze Commander's post changed with each Inspector's shift.

[110] As Silver Commander CI Paterson supported the Gold Commander in the control of the MISPER directing appropriate resources to it. She considered this MISPER complex as a consequence of, amongst other things, the geographical area to be covered. There had been no sightings of John Yuill and Lamara Bell and no evidence of financial transactions by them in the last 24 hours.

[111] As at the morning of Monday 6th July 2015 the live stream cameras on the A9 were not available to the MISPER. The Scottish Ambulance Service had no record of either John Yuill or Lamara Bell having been in their care.

[112] Details of John Yuill, Lamara Bell and the blue Clio were circulated to partner agencies in Loch Lomond, The Trossachs National Park, Forestry Commission and Fishery bailiffs who all have staff on patrol in the area.

[113] A case conference was chaired by CI Paterson at 12.00 hours on Monday 6th July 2015. The progress of the MISPER was considered. Further and extensive actions were identified and the following determined as priority, to be completed before the Gold Group meeting at 16.00 hours:

1. Those who had accompanied John Yuill and Lamara Bell to Loch Earn be re-interviewed.

2. Further telecom enquiries be made.

4. Financial checks be made on both.

4. POLSA to identify a search strategy and prioritise areas for search.

5. Development of a media strategy.

6. CCTV at identified sites to be checked.

7. East Overview to confirm fixed Automatic Number Plate Recognition ("ANPR") sites and to examine these sites for activation and a national check on speed cameras undertaken.

[114] The Gold Group chaired by Supt Stephen McAllister met at 16.00 hours on Monday 6th July 2015. POLSA confirmed that dog handlers were searching Comrie Moor Road. A search strategy was outlined by PS Alan Manson, a POLSA officer. That strategy confirmed that the most likely scenario was that the blue Clio had gone off the road. It was agreed that the MISPER would be discussed at the Local and Divisional meetings on Tuesday 7 July 2015 and a further Gold Group meeting convened if John Yuill and Lamara Bell remained untraced.

[115] It is worth pausing at this point to consider the extent of the searches conducted within 16 hours into the MISPER, to appreciate the intensity and dynamic nature of the investigation. In addition to the searches noted above, searches had been carried out from South Shore Road, Loch Earn through St Fillans and Comrie, Comrie Moor, the B8033 to Braco and Comrie Moor Road. The A9 from Perth to the Keir roundabout at Dunblane, a distance of 26.7 miles had been searched. The method of search, of the A9, was a slow drive along the carriageway/hard shoulder looking for any indication of the vehicle on or off the road.

[116] On Tuesday 7 July 2015 at 07.30 hours an instruction was given to check radio frequencies to exclude areas of mobile phone use.

[117] A case conference held on Tuesday 7 July at 12.00 hours ordered media updates and further searches of John Yuill's and Lamara Bell's property. Specialist searches were undertaken of these properties. All with negative results.

[118] An example of the tightness and management of this MISPER and its strategy is found in the records completed by Inspector Drummond after the Gold Group Meeting on 7 July 2015 at 17.00 hours. Under the heading "POLSA" what is noted is; *"Discussion regarding POLSA inactivity"*. In his overview of the MISPER following the meeting Inspector Drummond records the following when reflecting on that inactivity;

> "POLSA – This was a real issue for me as overview PI today. I was disappointed to find that no handover or forwarding action had been planned for today by the OSU/POLSA's from yesterday. No documentation had been left detailing what had been done, where and when and by whom, even right down to a pair of socks recovered at the campsite search last night and where they had been left and recorded etc……I spent a lot of today trying to get a meeting with POLSA and in particular have a lead POLSA identify to plan/conduct and co-ordinate the searches going forward. The search of the ping area itself is the centre of our universe, no matter the size and co-ordinated searches to find the vehicle are paramount. If we find the vehicle we will undoubtedly be closer to finding the mis pers."

He then sets out in detail what steps have been take to redress the issue and what orders have been given to POLSA. It is further noted that CI Paterson will ensure that these orders are progressed. CI Paterson confirmed her irritation at the lack of progress made by POLSA and that she had made that irritation clear to them.

[119] At 14.00 hours on Tuesday 7 July 2015, Inspector Kevin Chase commenced duty and assumed operational lead of the MISPER. His shift was due to finish at midnight.

During his shift he was informed that Liam Bell's debit card, which Lamara Bell had the use of, had been used at Broxden. Officers attended Broxden at around 01.30 hours on Wednesday 8 July 2015, when the CCTV was first available. They identified John Yuill and Lamara Bell, entering the shop at 05.40 hours on Sunday 5 July 2015. They could not download the CCTV or take possession of it at that time but noted that both John Yuill and Lamara Bell appeared uninjured. Lamara Bell was seen walking barefoot. That information was reported back to Inspector Chase at 01.30 hours, he was still on duty He instructed an interrogation of the A9 speed and ANPR cameras.

[120] At the Gold Group meeting held at 17.00 hours on Tuesday 7 July 2015, a Chief Inspector from Operational Support Division was appointed to oversee the MISPER and to prepare a media appeal.

[121] Between Tuesday 7 and Wednesday 8 July, there were five reported sightings of John Yuill and Lamara Bell. All reports were investigated and all found to be false.

[122] On Wednesday 8 July 2015, Sgt Goldie commenced duty at Falkirk police station at 09.00 hours. He updated the families of John Yuill and Lamara Bell on the progress of the MISPER. He asked if they would agree to take part in a media appeal. Diane Bell declined. Gordon Yuill agreed.

[123] At about 10.40 hours on Wednesday 8 July 2015, the blue Clio was found at the locus. This effectively brought the MISPER to a conclusion.

[124] At around 15.30 hours on Wednesday 8 July 2015, Sgt Goldie was contacted by CI Paterson and made aware of the circumstances of the John Wilson Call 1. She tasked him and Inspector Kellett to contact both families personally and to inform them of the

circumstances of the call. They were instructed to impart that information in a form of words prepared by Assistant Chief Constable Kate Thompson. The form of words is as follows;

> "Following our contact this morning, we would like to provide a further update with regard to the circumstances of this incident.
>
> As part of our investigation into this incident, it has come to light that a call was made to police late on Sunday morning regarding a car which was reported as being off the road. For reasons currently being investigated, police did not follow up that report. Following a further call this morning, officers attended the scene as per our update today.
>
> A full investigation is currently underway to establish the full circumstances of the incident. We will keep you updated as and when further information becomes available."

Comment on the MISPER

[125] The conduct of the MISPER was efficient, practical and in accordance with the SOP and all other associated guidance. Ownership of the investigation was established at an early stage. An appropriate command structure was quickly established. Officers with the necessary level of rank and expertise were identified. Senior officers directing the MISPER worked beyond their allocated shift to ensure progress was made. Where a lack of progress was identified it was promptly addressed as evidenced by the response to POLSA inactivity. Regular case conferences and Gold Group meetings were held to review the investigation and identify appropriate actions. In total 151 tasks were initiated in relation to John Yuill and 137 tasks initiated for Lamara Bell. All of these

tasks were conducted between approximately 23.00 hours on Sunday 5 July and the morning of Wednesday 8 July when the blue Clio was found.

Steps not taken

[126] The Crown asks that the Inquiry consider, with the benefit of hindsight, three decisions not taken as part of the MISPER. It is not submitted by the Crown that had these steps been taken a different outcome may have resulted. The exercise is designed to identify what, if any lessons, may be learned from these omissions which may assist future MISPERs. The three omissions are:

1. How the North Safety Camera Unit ("NSCU"), Dundee, dealt with the PNC marker when issuing a Notice of Intended Prosecution ("NIP").
2. The decision not to search the M9 and adjacent land from the Keir Roundabout south to Falkirk.
3. The failure to make a retrospective request for the southbound A9 average speed camera data.

How the NSCU dealt with the PNC marker when issuing a NIP

[127] The blue Clio was captured by a speed camera on the A9, northbound, between Tibbermore and Broxden at 05.31.09 hours on Sunday 5 July 2015. It was recorded travelling at a speed of 91mph. A "speeding ticket" was prepared for service upon the registered keeper. The processing of that "speeding ticket" is the responsibility of NSCU, Dundee. The NSCU are a team within Operational Support Division, Roads

Policing. It deals with the administration of speeding offences detected by Mobile and Average Speed Cameras. A "speeding ticket" was served on John Yuill's sister as the registered keeper but subsequently withdrawn.

[128] A marker was put on the PNC at around 09.48 hours on Monday 6th July 2015. The marker is clear in its terms; *"Low stop details check driver/occupant details maybe MISPER. Maybe travelling in this vehicle"*. That marker would have been available on the NSCU system at around 10.20 hours, same date. No request was made for the NSCU data to be searched.

[129] On Wednesday 8 July 2015, Fiona Turgill processed the "speeding ticket". She was then a Management Officer in NSCU. She had been in that post for 15 years and experienced in the management and administration of traffic offences. She had basic training in what a *"Lo-Stop"* and *"Hi-Stop"* marker was. When processing a "speeding ticket" she would note the terms of any marker. She recalled this particular process due to the clarity of the photographs and the fact that both the driver and the passenger looked happy. She did not recall the terms of the marker. Even if she had, she would not have considered it relevant as she was only looking for details of the registered keeper, and a number of days had passed since the capture.

[130] MISPERs may be assisted by data from speed camera captures. The Crown submits that a reasonable precaution was for the MISPER team to request data from NSCU once the marker was in place. Had that been done the location of the blue Clio would have been accurately established. That location was in a direction north and away from where the blue Clio was ultimately found. By 10.20 hours on the morning of

Monday 6th July 2015, the telecom data indicating a similar direction of travel was known and being acted upon. Had the NSCU data been requested and received it would not, realistically, have resulted in the deaths of John Yuill and Lamara Bell being avoided. The failure of the MISPER team to request the NSCU data is a defect in a system of working. That defect did not contribute to the deaths.

[131] Lessons have been learned as a result of the failure to request NSCU data and the way in which data was dealt with at NSCU. In May 2020, Police Scotland published the *Safety Camera Unit – Toolkit.* Paragraph 9.1 of that document regulates the process of issuing a NIP and includes an instruction to check for markers. Administrators are instructed to report that information to the investigating officer. In these circumstances, the Crown do not invite any recommendations in regard to the examination and processing of speed camera data.

The decision not to search the A9 south from the Keir roundabout to Falkirk

[132] On the morning of Monday 6th July 2015 the A9 carriageway was searched from Perth south to the Keir roundabout for the blue Clio. The search was performed by police officers travelling the A9 slowly looking for any signs of a collision or a vehicle having left the carriageway. If any signs were detected then a search of the area, on foot, would be carried out. Sergeant Ruth Aitchison confirmed that the damage to the tree line and the marks on the kerb, seen at the locus, are examples of what would alert search officers attention. If observed, she would expect the area to be searched. Had that happened then in all likelihood the blue Clio would have been discovered. Why

then was the search not continued south on the M9 to Falkirk? It may seem an obvious action to take. The SOP directs that any routes that may be taken by missing persons should be considered for search. In one sense that question has been answered in considering the efficacy of the MISPER, and is based on the very early hypothesis that the blue Clio had gone off the road. The MISPER team were following the evidence and intelligence available to them at that time. The early evidence was that the vehicle was travelling north, away from the locus. The logistics involved in the search of the "place last seen", a wild camp site at Loch Earn, and surrounding areas was immense. A great deal of resources were allocated to that search and it took time. CI Paterson described that search as a proportionate, logistically focussed investigation. I agree with her assessment. Once the Broxden CCTV footage became available, a new "place last seen" was identified prompting a review of the search strategy. That evidence was not available until early on Wednesday 8 July 2015, a matter of hours before the blue Clio was found leaving little time to react to it.

[133] CI Paterson accepted, with the benefit of hindsight, that once the blue Clio was found then it was obvious that a search of the M9 south to Falkirk should have been undertaken. Without hindsight, she did not think she would have conducted the MISPER differently. She had no doubt that once the search of the area around Loch Earn had been exhausted, a search of the M9 south would have commenced. That opinion was shared by Sergeant Goldie. He saw the plan as identifying the "place last seen" and then working the search out from there in line with the evidence. As each route was determined and searched and the blue Clio not found, the M9 south would

become a focus for search. Inspector Reid had a stronger view of the efficiency of the search. It did not occur to him that the M9 south should be searched, because he was following the intelligence and evidence available to him. It is difficult to argue with Inspector Reid's analysis. He was applying the terms of the SOP to the particular circumstances of this search. PC Karen Leadbetter an experienced POLSA officer expected that the M9 south would have been searched at some point, but as the "*ping of the phone*" indicated an area north of Blackford, the search was properly focussed.

[134] The Crown submits that the decision not to search the M9 south from the Kier roundabout was a reasonable one. I agree, but would go further. Based on the available evidence and as guided by the SOP the MISPER was a logical, tightly controlled, evidence based investigation which was properly resourced. The idea that all of the possible routes from Loch Earn to Falkirk could have been searched within the first 48 hours of the MISPER is untenable.

[135] The Crown submits that a search of the M9 south was a precaution which could have been taken from Monday 6th July 2015 onwards. That, with the benefit of hindsight, is difficult to refute. It was not, however, a reasonable precaution to have taken prior to, at the earliest, the discovery of the CCTV at Broxden. Sadly by that time John Yuill had been dead for more than two days and any medical assistance afforded to Lamara Bell would not have avoided her death. It cannot be said that the failure to search south of the Keir roundabout would have realistically resulted in the deaths of John Yuill and Lamara Bell being avoided.

[136] In all of the circumstances, the failure to search south of the Kier roundabout was not a defect in a system of working

The failure to make a retrospective request for the southbound A9 average speed camera data.

[137] Once the blue Clio left Broxden, it travelled south on the A9 towards the Keir roundabout and ultimately the locus. The A9 south to the locus is covered by eleven average speed cameras. Data, the VRN of vehicles entering and exiting the zone covered by these cameras is stored whether or not the vehicle violates the speed limit. That information would have been of value to the MISPER. Due to data retention policies it is not possible to confirm which, if any, of the average speed cameras were operational on Sunday 5 July 2015.

[138] The value to the MISPER of information from speed cameras was not lost on the team. At the Gold Group case conference on Monday 6th July 2015 at 12.00 hours, one of the tasks (task 14) set was to have East Overview identify and interrogate ANPR fixed sites and speed cameras for activation by the blue Clio. The Gold Group reconvened at 16.00 hours the same date. The minutes of that meeting note the following; *"ANPR: 4 fixed sites in Scotland on the M8, Forth Road Bridge, Gilmartin, Dumfries and Galloway. All fixed sites in Scotland and England have been interrogated and no trace of MP's vehicle."* Officers were reminded that the system should be regularly checked, as is not automatically shown that a looked for vehicle has triggered the system. The system was checked as late as 00.40 hours on 8 July 2015 with negative results.

[139] Prior to the 16.00 hours Gold Group case conference, Inspector Reid contacted East Overview requesting data from the A9 speed cameras and associated areas. He was told that there was no live stream of information but a "*retrospective request*" could be made to see if the cameras had been activated. The A9 average speed cameras were then, and are now, under the control of the NSCU, Dundee. Average Speed Cameras capture all vehicles entering and leaving the relevant zone. Vehicles violating the speed limit are processed for prosecution. The VRN details of all vehicles, whether they violate the speed limit or not, are held on a data base. Violation data is downloaded once per week to enable prosecutions to commence. Non-violation data is downloaded once per month. It is held in the system and available for searching for 30 days. Disclosure of that data will only be permitted for a valid reason. One such valid reason is a MISPER.

[140] At no time during the MISPER was NSCU asked to search for non-violation data on the blue Clio from the A9 speed cameras. As at 2015 there were very few requests for such data. There was no general awareness of data stored. Once the "place last seen" became Broxden, on the morning of Wednesday 8 July 2015, CI Paterson instructed Inspector Kellett to review data from the A9 Average Speed Cameras as a matter of urgency. CI Paterson, at least, was aware of the availability of a retrospective search at that time. As it transpired, the discovery of the blue Clio only hours later made any search redundant.

[141] A search of the A9 average speed cameras was a precaution that could reasonably have been taken. Had it been done it would have not realistically resulted in

the deaths of John Yuill and Lamara Bell being avoided. At best it may have influenced the search strategy and resulted in the blue Clio being found earlier than it was.

[142] The failure to search for data on the A9 average speed cameras was a defect in a system of work. That defect did not contribute to the deaths of John Yuill and Lamara Bell.

[143] Police Scotland recognised then, and it has been emphasised since, that interrogation of fixed, average and mobile speed cameras could provide vital information in the conduct of a MISPER. The misunderstanding as to what data is available from these cameras has been dispelled. The opportunity to request retrospective searches is now understood. In May 2020 the *Police Scotland Safety Camera Unit – Toolkit* was published. The toolkit along with training evolved since July 2015 means that a marker such as placed on the blue Clio, would result in the sighting being notified to the MISPER team.

[144] These three omissions are omissions which in a different context may have had an effect on the outcome of the MISPER. In the context of this Inquiry they did not materially do so. The omissions have all been recognised and addressed appropriately by Police Scotland and the NSCU. In these circumstances the Crown do not seek any formal Recommendation nor invite the Inquiry to make findings under section 26(1) (a) and 2 (e) or (f).

14. Robert Findlay's call.

[145] Robert Finlay is a farmer. His farm at Pirnhall is situated around the locus. At around 09.30 hours on Wednesday 8 July 2015 he saw the blue Clio at the bottom of the embankment. He decided to investigate. On approaching the vehicle he saw John Yuill in the driver's seat and Lamara Bell in the passenger's seat. He recognised immediately that John Yuill was dead. He heard Lamara Bell say "*Help me*" and "*Get me out*". Mr Findlay sought to comfort and reassure her that he would before climbing up the embankment and onto the hard shoulder of the M9, to get a better signal for his mobile phone and summon assistance.

[146] On reaching the M9, he tried to stop passing vehicles to help him. Eventually one did and the driver parked on the hard shoulder with hazard lights on. At 09.49 hours Mr Findlay called 999 requesting police, fire and ambulance services to the location. He returned to the blue Clio to comfort Lamara Bell. She became more distressed and disorientated by his presence so he returned to the hard shoulder of the M9 to await and direct the emergency services to her.

[147] Mr Findlay is to be highly commended. Appreciating Lamara Bell's plight he immediately summoned the emergency services. In doing so he put himself in no little danger. He stood by the side of the M9 trying to get other motorists to stop and help him. The M9 was busy with traffic. He returned to the vehicle to provide what comfort he could to a young woman suffering dreadful injuries and greatly distressed. He struck me as a calm, assured man and he went about his business that day in that manner.

15. The Emergency Services response to Robert Findlay's call

[148] One of the purposes of this FAI is to seek to restore public confidence and allay public anxiety arising from the failings which give rise to it. The response of Police Scotland and all other emergency services to Robert Findlay's call should serve to provide that reassurance. The procedures undertaken by Police Scotland, Scottish Fire and Rescue Service ("SFRS"), Scottish Ambulance Service ("SAS") and the Emergency Medicine Retrieval Service ("EMRS") were conducted in accordance with their standard operating procedures, and to good effect.

[149] Robert Findlay's 999 call was answered immediately. The Area Control Rooms began allocating resources at around 09.54 hours.

[150] Around 09.59 hours on Wednesday 8 July 2015, SFRS at Stirling received a call from control to attend a road traffic collision at the locus. Craig O'Donnell, Watch Commander, and a crew arrived within 10 minutes. On arrival he met Robert Findlay who told him that there were two people in the car a male and a female, the male was dead and the female badly injured, but alive.

[151] Craig O'Donnell saw the car at the foot of the embankment on its four wheels. The roof was significantly deformed on the driver's side and the passenger's door open. A fallen tree lay on the back of the vehicle. The windscreen was on the bonnet of the car. The driver's door was no longer on its hinges but locked in place. Lamara Bell was in the passenger seat. Her legs were on the dashboard.

[152] Within ten minutes of SFRS arrival the first paramedic arrived. He instructed SFRS to take Lamara Bell from the car as soon as possible. SFRS removed the roof of the vehicle and she was taken from it on a spinal board.

[153] SFRS removed John Yuill from the blue Clio and delivered him to the awaiting undertakers. That brought SFRS involvement to an end. In one sense the involvement of SFRS could be left there. That would do an injustice to the role of firefighter Iain Lockhart. His evidence is important in understanding Lamara Bell's level of consciousness when he first engaged with her and throughout the operation to rescue her.

[154] Iain Lockhart was at the time of the incident a firefighter with seven years' experience. On the way to the locus he was designated as the Casualty Carer. The Casualty Carer cares for casualties while other fire fighters perform their allocated tasks.

[155] On arrival Iain Lockhart noticed that Lamara Bell's legs were moving. As he neared the vehicle she became aware of his presence and said; *"Get the fuck away, I don't want to come out of here. Get the fuck away from me".* He thought that her combative behaviour was borne out of her head injury and embarrassment at the condition of her clothing. He told her that his name was Iain, that he was a firefighter and there to help her.

[156] Iain Lockhart examined her for injuries and assessed her level of consciousness. He did not know how long she had been there and assumed that it was a recent accident. Her condition, as he found it, caused him some confusion as her injuries appeared to be old.

[157] The well on the passenger's side of the vehicle had water in it and there was a strong smell of urine.

[158] Throughout his examination he continued to communicate, comfort and reassure her that she was being rescued. He tried to keep her conscious and talking. He asked her name and she replied "*Lamara*". She confirmed her surname as Bell and that she was 29. She thought she had been in the car for about 20 minutes, but did not know what had happened. She could not remember his name. Throughout this time he administered oxygen to her.

[159] Iain Lockhart stayed with Lamara Bell while the roof was removed with hydraulic cutting gear. During that time a heavy tarpaulin was placed over them to protect them from cutting debris.

[160] To assist her removal from the vehicle Iain Lockhart supported Lamara Bell's head. She screamed in pain at the first attempt to remove her and, as he put it, she had a "*Pop at him*" with her left hand. While she was being taken to the air ambulance she had a firm grip of the paramedic's jacket and would not let go.

[161] Iain Lockhart was joined by a paramedic, Mr James Stewart. James Stewart was at the time SAS Area Manager for Forth Valley. He is a qualified paramedic and has been since 1994. He is trained in scene management.

[162] On Wednesday 8 July 2015, he was notified of the incident at 10.04 hours and arrived at the locus at 10.11 hours. When he arrived at the blue Clio he was quickly aware that John Yuill was dead. He formally pronounced John Yuill dead or "*life extinct*" at 10.16 hours.

[163] When he spoke to Lamara Bell she told him to leave her alone. He tried to engage her in conversation but she gave only a mumbled response. She responded to pain. The appearance of severe bruising around her eyes, which he described as *"Raccoon Eyes"* or periorbital ecchymosis, and that her right eye was fully dilated gave him a clear indication that she had suffered a severe head injury and possibly a base skull fracture. Her left eye was constricted. She had poor movement in her lower limbs and her right arm was deformed and fractured. He inserted a cannula into her right arm in preparation for the administration of medication when the medics arrived.

[164] Lamara Bell was confused and becoming incomprehensible. Mr Stewart assessed her on the Glasgow Coma Scale ("GCS") as 9/15. The GCS is a clinical scale used to measure a person's level of consciousness following a brain injury. The scale is comprised of three criteria:

1. Eye or ocular response.
2. Verbal or oral response.
3. Motor response.

A fully conscious adult will score 15. An unconscious and unresponsive adult will score 3. In general terms a score of 8 or less gives an indication of severe brain trauma, a score between 9-12 gives an indication of moderate brain trauma and a score of between 13-14 mild brain trauma.

[165] Scotland's ERMS provides pre-hospital critical care and safe transfer to hospital for, amongst other things, people involved in road traffic accidents. The ERMS team is ready to respond, by helicopter, within minutes of a request to do so. The team is

comprised of Consultants, Doctors and practitioners from a paramedic or nursing background. It is equipped to provide pre-hospital emergency anaesthesia and pain relief.

[166] On Wednesday 8 July 2015, Mr Richard Price, Consultant in Anaesthesia and Intensive Care Medicine commenced his shift at ERMS at 08.00 hours. He was joined by Dr Ross Moy, Registrar in Emergency and pre-hospital medicine, and Paramedic Jason Mortimer. The team were tasked to attend the locus at 10.09 hours and arrived by helicopter at 10.30 hours. He examined Lamara Bell and found her to have a reduced level of consciousness, a significant head injury and a reduced GCS. She was unaware of her surroundings and hypothermic. Her verbal response was incomprehensible. He administered Ketamine for pain relief. He noted a significant head injury and fractured right forearm. He noted no other major injuries at that stage but suspected that she had suffered internal injuries given the force of the collision. He considered her injuries life threatening. He induced general anaesthesia and started controlled mechanical ventilation, standard treatment for people suffering a severe head injury. She was then transported by air-ambulance to the Queen Elizabeth University Hospital ("QEUH") for further investigation and treatment.

[167] The helicopter departed the locus at 11.32 hours and the ERMS team handed over the care of Lamara Bell to the team in the Emergency Department at QEUH at noon.

Police Scotland's response

[168] Police Sergeant Ruth Aitchison was at the time of the accident a police officer with 11 years' service, six within the Road Policing Unit. She has a diploma in Road Policing Operations. She is trained as a Senior Investigating Officer in road deaths. She is a Tactical Pursuit Adviser and trainer having obtained relevant qualification from the Scottish Police College.

[169] PS Aitchison commenced duty at 07.00 hours on Wednesday, 8 July 2015, along with PC Richard McEwan. At around 09.55 hours she was tasked to attend at the locus. On arrival, she saw Lamara Bell sitting in the front passenger seat moving her head from side to side as though acknowledging something.

[170] PS Aitchison instructed a full road closure of the M9, eastbound prior to the junction 9 off slip. She summoned assistance from other police units before speaking to Robert Finlay.

[171] Craig O'Donnell told her that the driver was dead and that the female passenger, very seriously injured. She contacted the ACR to confirm the condition of those in the car.

[172] Craig O'Donnell gave her a purse recovered from the passenger side of the blue Clio containing a photographic identification card issued by Forth Valley College in the name of Lamara Bell. She contacted the ACR confirming identification and was told that Lamara Bell was a missing person and that the driver was probably John Yuill. She requested a member of the MISPER team attend to confirm his identification. Sergeant Alastair Goldie arrived and did so.

[173] She instructed PC McEwan, and PC Adam Weir, Advanced Collision Investigators, to conduct a full collision investigation. She had the Procurator Fiscal and senior OSG management advised of the situation and requested a police helicopter take aerial photographs of the locus. The ACR made the media aware of the road closure.

[174] PS Aitchison requested the attendance of an undertaker to attend to John Yuill. She made arrangements for the families of John Yuill and Lamara Bell to be informed of the circumstances. She appointed PC Simon Murray as family liaison officer to the Yuill family and instructed him to arrange a formal identification later that day.

[175] At 15.05 hours, the collision investigation was complete. The blue Clio was removed by MTS Recovery and taken to its yard. The M9 was then opened to traffic.

[176] Although this chapter relates to the emergency services at the locus after Robert Finlay's call, for the sake of completeness I outline what other involvement Sgt Aitchison had over the coming days.

[177] On Thursday 9th July 2015, she tasked officers to search the locus to ensure all items of a personal nature had been recovered from the blue Clio. A search of the blue Clio was made at the yard of MTS Recovery.

[178] On Friday 10 July 2015, she was told that the post-mortem of John Yuill was scheduled for Monday 13th August 2015 at 09.30. She tasked PC Murray to inform John Yuill's family of the time and date. At 12 noon, same day, she met with Gordon Yuill, Anita Dollard and Paul Mooney at the MOTO Services, Pirnhall to enable them to view the locus. At 14:15 hours, along with PC Murray, she attended the home of

Gordon Yuill and read to him and Anita Dollard a prepared statement regarding the John Wilson's Call 1.

[179] On Sunday 12 July 2015, she was briefed on the arrangements for Lamara Bell's body to be transferred to the Edinburgh City Mortuary. Her family did not wish to carry out a formal identification and so she arranged an alternative means of identification

16. John Wilson's call 2

[180] On Wednesday 8 July 2015, John Wilson was travelling home from Stirling at around 10.30 hours. His father phoned and told him that he was on Pirnhall Road and a helicopter and emergency services were at the car they saw on Sunday morning. He travelled to the locus and watched what was developing. He realised that someone in the vehicle must be alive. John Wilson found the scene extremely upsetting. It caused him to be angry. He left the locus and returned home.

[181] John Wilson called Police Scotland on 101 at 10.52 hours on 8 July 2015 and spoke with a call handler. He told the call handler that he had reported the same car off the road on Sunday 5 July 2015 at 11.28 hours. He was extremely upset and incredulous that his first call had not been acted upon. He told the call handler that he was aware, from media reports, that two people were missing from Loch Earn having been last seen on Sunday 5 July 2015 in a blue car. It was this call which set in motion the investigation into his first call, and the investigation into Police Scotland's call handling.

[182] John Wilson was an impressive witness. He had the air of a man with considerable strength of character. He was deeply troubled by these events. He was, and remains, angry that Police Scotland did not action his first call. The consequences of that failure compounds his anger and sense of disappointment. He has strong views on what should happen to those who failed John Yuill and Lamara Bell. He is an example of someone who has had his confidence and trust in Police Scotland eroded as a result of this experience.

17. Medical evidence, time and cause of death of John Yuill

[183] The road traffic accident which resulted in the death of John Yuill occurred between 06.00 hours and 06.15 hours on Sunday 5 July 2015. John Yuill's time of death was at or around 06.50 on Sunday 5 July 2015.

[184] Mr James Stewart, paramedic, pronounced John Yuill dead at 10.16 on Wednesday 8 July 2015.

[185] John Yuill's remains were removed from the blue Clio and taken to Edinburgh City Mortuary. On Monday 13th July 2015 Dr Ian Wilkinson and Dr Robert Ainsworth, Consultant Forensic Pathologists, carried out an autopsy examination and prepared a post-mortem report, issued on 24th September 2015. Dr Fiona Wylie and Ms Denise McKeown, Forensic Toxicologists, completed a toxicology report dated 11th August 2015. Dr Antonia Torgersen and Professor Colin Smith, Consultant Neuropathologist, prepared a neuropathology Report dated 4th September 2015. From these reports the following is concluded:

(i) John Yuill's death was due to head and abdominal injuries. These injuries are consistent with injuries sustained in a road traffic accident.

(ii) John Yuill's body showed features of decomposition giving an indication of death having occurred around, or shortly after, 06.00 hours on Sunday 5 July 2015.

(iii) John Yuill had sustained multiple blunt force injuries, the majority being to the head and neck. He sustained associated fractures to his face and skull.

(iv) He sustained displaced fractures to his right arm and right leg.

(v) Internally he sustained gross blunt force head trauma with multiple fractures to the cranial vault. He sustained fracturing to the skull base, multiple facial fractures and two left sided rib fractures.

(vi) Bruising was evident in his abdominal/pelvic wall muscles. There was a comparatively large volume of blood in his abdomen. Multiple tears of his liver and small bowel mesentery were evident.

(vii) He suffered significant trauma to his brain with signs of direct and rotational injury.

(viii) The presence of axonal injury within the brain suggests a short survival period post-accident of, at most 35 minutes. He would have been rendered unconscious from the time of the collision.

(ix) Post mortem toxicology revealed blood and urine alcohol levels of 148mg/dL and 203mg/dL respectively. These figures are approximately three times the drink drive limits of 50mg/dL and 67mg/dL respectively. There is

potential for the body to produce alcohol naturally after death and during decomposition. It cannot be said with any certainty that these figures accurately reflect the amount of alcohol in his body at time of death.

(x) Post mortem toxicology revealed the presence of the active component of cannabis and its inactive metabolite, consistent with consumption within a period of 6 hours pre accident. The level of the active component was found to be 26ng/ml. Mathematically that equates to 0.026mg/mL or 26mg/L, well in excess of the 2mg/L specified in The Drug Driving (Specified Limits) (Scotland) Regulations 2019.

(xi) John Yuill's cause of death was as a result of the severe head trauma he suffered in the accident contributed to by the intra-abdominal injuries.

[186] By the time of the John Wilson Call 1, John Yuill had been dead for a number of hours. It is difficult is to be definitive about how long he would have survived post-accident, but the post mortem findings suggest a short survival time of at around 35 minutes.

[187] Mr Mathew Crocker, now deceased, then a Consultant Neurosurgeon at St Georges Hospital, London prepared a report on the death of John Yuill from a neurological perspective. His report is dated 29th June 2016. He concluded that it was likely that the impact of the collision caused John Yuill to stop breathing immediately followed by circulatory failure and cardiac arrest. He then suffered widespread bleeding to sites other than the brain causing loss of cardiac output and death.

[188] As a result of the collision John Yuill suffered injuries so severe that they were not survivable regardless of the timing of medical intervention.

18. Medical evidence, survivability, time and cause of death of Lamara Bell

[189] Once received into the care of Jonathon Gordon, Consultant in Accident and Emergency Medicine at QEUH, an initial assessment of Lamara Bell was undertaken. The positioning of the ventilation tube inserted at the locus by the ERMS team was correct. Air was being ventilated to both sides of her chest. Her pulse rate was recorded at 139 beats per minute, too high and too fast. Her blood pressure was recorded as 83/67, too low. Her right pupil was dilated. She had a fracture to her right arm. She was administered intravenous antibiotics.

[190] On arrival at QEUH, Lamara Bell was hypothermic. Her body temperature was too low. A gentle process of body warming was undertaken with the aid of a warming blanket and intravenous heated fluids.

[191] Following initial assessment she was transferred for a CT scan. Her head, neck, abdomen and pelvis were scanned. The scan confirmed a fracture to her skull and the presence of blood and air in her brain.

[192] Once her body temperature was raised she was transferred to the Intensive Care Unit at the Institute of Neurosciences (‘NITU’) at the QEUH, under the care of Mr Likhith Alakandy, Consultant Neurosurgeon. On admission to the NITU she was still sedated, intubated and ventilated. A probe was inserted into her right frontal lobe to

monitor intra-cranial pressure ('ICP'). Her ICP was found to be moderately high but, over the course of 48 hours, settled to within normal limits.

[193] On Thursday 9th July 2015 her sedatives were reduced. Her GCS was assessed at 3 from 9 on admission. She was responding only to painful stimuli. A further CT scan was undertaken. It disclosed nothing to explain the deterioration in her GCS score.

[194] On Friday 10th July 2015 Lamara Bell's condition deteriorated further. She was assessed as suffering from hydrocephalus, a build-up of fluid on the brain. She was taken to theatre for surgery. A drain was sited to relieve the pressure on her brain. During surgery her cerebrospinal fluid ('CSF') was found to be under pressure. A sample of her CSF was sent for review.

[195] On admission to QEUH Lamara Bell was suffering from, amongst other things:

1. Acute kidney trauma.
2. Increased sodium levels as a result of dehydration.
3. The effects of traumatic brain injury.
4. Raised creatinine kinase, giving an indication of muscle damage.

[196] Blood tests recorded a raised white cell count of 45/cu with 90% polymorphs giving a clear indication of infection but no pathogenic bacteria were isolated. On admission she was treated with the antibiotics Ceftriaxone and Metronidazole. As at 10th July 2015, Flucloxacillan was added.

[197] No improvement in her condition was noted on Saturday 11th July 2015 and a further CT scan was undertaken, which disclosed decompression of parts of her brain

and a reduced blood flow (ischemia) to both frontal lobes. The drain earlier inserted had stopped draining CSF. Her GCS was fluctuating between 4 and 5.

[198] Throughout Saturday 11th July 2015, her condition continued to deteriorate. Dr Christopher Love examined her at around 00.30 hours on Sunday 12th July 2015. He noted that her right eye was abducted, the pupil dilated and unresponsive to light. After a further CT scan it was decided that no further medical intervention was appropriate. Her family were contacted and advised of that decision and its consequences.

[199] Over the next six hours her condition continued to deteriorate. At 06.30 hours she was found to have, high blood pressure, a high heart rate and both her pupils were fixed and dilated.

[200] At around 06.38 hours her heart stopped, she was not breathing, she had no central pulse, she was not responding to pain stimulus and her pupils remained fixed and dilated.

[201] At 06.48 hours on Sunday 12th July 2015, Lamara Bell was pronounced dead.

[202] Lamara Bell was transferred from QEUH to the City Mortuary, Edinburgh on Monday 13th July 2015 for autopsy examination. The autopsy was carried out by Consultant Pathologists Dr Ian Wilkinson and Dr Robert Ainsworth.

[203] Toxicology investigations were carried out by Forensic Toxicologists, Dr Fiona Wylie and Ms Denise McKeown. Further investigations were carried out by neuropathologists, Dr Antonia Torgersen and Prof Colin Smith.

[204] An external examination of Lamara Bell identified a large number of injuries to her head, neck, trunk and all four limbs. Some of these injuries showed signs of healing. The injuries are consistent with those sustained in a road traffic accident. Some injuries were consistent with the effects of prolonged exposure to irritant substances, for example urine.

[205] An internal examination identified a complex fracture of the base of the skull with underlying brain injury.

[206] She had suffered Bronchopneumonia.

[207] Neuropathological examination confirmed extensive contusions to the base of her brain. As a result of the rotational head injury, she suffered diffuse traumatic axonal injury ('DTAI'). She had suffered widespread damage to her brain's nerve cells. This examination identified the presence of acute and rapidly developing meningitis, resulting in inflammation of the tissue covering her brain and spinal cord causing a lack of blood to her brain.

[208] When discovered in the blue Clio on Wednesday 8 July 2015, Lamara Bell had been exposed to the elements for three days. As a consequence of that exposure, she developed symptoms secondary to the DTAI. She experienced physiological changes including dehydration, acute kidney failure, hypotension and increased levels of sodium.

[209] Identifying established infections quickly and administering early treatment is essential in improving outcomes in the management of trauma. Lamara Bell was denied

this early intervention. Due to the passage of time these secondary symptoms became more acute and difficult to manage.

[210] The primary head injury, caused in the accident, was the DTAI. That injury caused swelling to her brain. As at Wednesday 8 July 2015, her GCS was assessed as 9. That score is not indicative of a fatal head injury in an otherwise healthy 25 year old person. While being treated at QEUH Lamara Bell suffered a series of adverse physiological and biochemical issues causing additional and severe secondary swelling to her brain (cerebral oedema) and ultimately infarction. Infarction is the pathological process of tissue death due to inadequate blood supply to the affected area, in this case her brain. Biochemically she suffered severe dehydration, renal failure and fluid shifts. She suffered systemic infection and meningitis. A significant factor in the cause of the secondary brain injury was hypothermia, manifest at the time of her rescue.

[211] As a consequence of the additional brain swelling Lamara Bell suffered a secondary, very severe brain injury and death. Her cause of death was multifactorial. Had she been admitted to hospital on Sunday 5 July 2015 the primary head injury would have been managed and any secondary complications arising from it substantially avoided. Had she received medical treatment on Sunday 5 July 2015, Lamara Bell would probably have survived. Had she survived she would have suffered a long term neurological deficit.

[212] The post mortem recorded Lamara Bell’s cause of death as 1(a) Complications arising following a road traffic accident (front seat passenger).

19. The time, collision investigation and causation of the accident

[213] The Crown raise the issue of whether or not the events leading to the blue Clio leaving the carriageway are properly defined as an 'accident'. It is without question a collision. 'Accident' is not defined in the Act nor its statutory predecessor. What constitutes an accident has been considered in the context of road traffic legislation case law and in particular *Pryde v Brown* 1982 SLT (Notes) 314. What can be taken from *Pryde* is that each case is considered on its own facts and circumstances, looked at on a common sense basis. A simple definition of 'accident' must be that what occurred was unintentional, unfortunate and as a result of at least carelessness or ignorance or a combination of both. There is no evidence to suggest that the blue Clio left the M9 carriageway other than unintentionally. Taking account of the collision investigators conclusions and other evidence, what happened to the blue Clio constitutes an accident.

The time of the accident

[214] I conclude that the accident occurred sometime between 06.00 hours and 06.15 hours accepting that:

1. Between 05.40 hours and 05.43 John Yuill and Lamara Bell were at Broxden.
2. A police reconstruction of the journey between Broxden and the locus at a consistent speed of 70 mph took 30 minutes.

If after leaving Broxden John Yuill drove at the national speed limit throughout the journey to the locus he would have arrived at around 06.15.

Collision Investigation

[215] Constables Richard McEwan and Adam Weir investigated the cause of the blue Clio leaving the carriageway. Both officers are qualified Collision Investigation Officers. Their expertise and qualifications were never challenged.

[216] The blue Clio was found at the foot of the embankment at the locus. It was facing the opposite way from the direction of travel. The driver's side of the vehicle was parallel to the fence. It was sitting on all four wheels. From leaving the hard shoulder it travelled a distance of 21 meters through the area of trees and dropped 4.3 meters to its resting position.

[217] There were no eye-witnesses to the accident. There was limited physical evidence to enable a forensic conclusion to be reached as to the cause of the blue Clio leaving the carriageway. The cause of the accident is determined by inferences drawn from available evidence.

[218] No contaminants were found on the road surface at the locus which could have contributed to the accident. There was no damage to the road surface which could have contributed to the accident. There had been no reported accidents at the locus in the three years up to July 2015. There were no adverse weather conditions which could have contributed to the accident.

[219] No tyre marks were found on the carriageway at the time of inspection. Side-way tyre scuff marks were found on the hard shoulder measuring 8.5 and 8.8 meters in length. Furrows on the grass verge leading to a fallen tree were evident. Scrape marks

were found on the low angled kerb. These marks gave a clear indication of the blue Clio's path from the carriageway to its resting place.

[220] On examination, at the locus, the blue Clio was found to have sustained significant damage to the front driver's side. The roof of the vehicle had suffered a significant impact causing a massive intrusion into the driver's area. A semi-circular intrusion was found on the driver's door and seat. This damage is consistent with collision with a tree. Pieces of tree bark and other vegetation was found embedded in the bodywork of the vehicle.

[221] Numerous trees around the vehicle were damaged, including a fallen tree, giving an indication of the path of the vehicle to its resting place. The fallen tree, measuring 0.4 meters in diameter, was broken at its base. A tree 10 metres east from the vehicle was heavily damaged. A section of bark had been removed from the tree and black tyre marks found on the trunk. Glass from the driver's side headlamp was found in the branches of the tree. A section of the front bumper was found in the undergrowth. A tree situated three meters from the vehicle showed evidence of heavy impact.

Examination of blue Clio

[222] The blue Clio was examined at garage premises in Stirling on Monday 13th July 2015 by Constables McEwan and Weir. The vehicle is a blue, three door hatchback. It has a 5 speed manual gearbox and a 1149cc, 4 cylinder petrol engine. It was first registered on 30th March 2005 and MOT'd until 6th April 2016. The odometer was so badly damaged as to make reading of the mileage impossible.

[223] The condition of the wheels and tyres will be considered separately.

Examination of the vehicle disclosed the following:

(i) The lights and instrument panel could not be checked due to collision damage.

(ii) The driver's and front passenger's side airbags had been deployed. The steering wheel and dashboard airbags had not.

(iii) The steering wheel was folded forward at approximately 45 degrees.

(iv) The gear lever linkage was detached and offered no resistance. There was no indication of which gear was engaged at the time of the collision.

(v) The driver's seat belt buckle was engaged. The belt had been cut to enable John Yuill to be removed from the vehicle.

(vi) The passenger's seat belt had been cut by SFRS, to enable the vehicle's roof to be removed. The buckle was not engaged.

(vii) The vehicle is fitted with an Anti-lock Braking System consisting of discs and pads at the front and drums and shoes at the rear. The surface of the pads were contaminated with rust as a result of the vehicle sitting, immobile, for three days. The discs were in good condition and the pads recently replaced. The shoes and drums although worn were in good working order. The rear driver's side brake cylinder was damp giving an indication of brake fluid leakage. This would not adversely affect performance. At the time of the collision the braking system was in good working order and did not contribute to the collision.

(viii) The steering linkage was intact and operational although limited due to collision damage.

(ix) The vehicle sustained significant collision damage to the front driver's side. A major semi-circular intrusion was evident. That damage is consistent with the vehicle striking a tree.

(x) The roof of the vehicle was extensively damaged on the driver's side showing a semi-circular pattern. The roof had been pushed in on the driver's side. This damage is consistent with the car having collided with a tree.

(xi) The driver's side and door suffered significant impact damage. The sill was pushed inwards by 0.7 meters from its original position. The driver's seat was compressed to half its normal width.

(xii) The C pillar, a roof support, was pushed inwards and down.

(xiii) The driver's side front strut, part of the suspension, was broken in two.

(xiv) The drivers' side front wing was destroyed in the collision as were the headlights.

(xv) The grill and front structure of the car including the bumper mounting and bonnet were extensively twisted. The front bumper was detached from the vehicle and split in two.

(xvi) The bodywork of the car had pieces of tree bark and other vegetation embedded in it as had the wheels.

(xvii) Both front tyres were deflated and the front wheels damaged.

[224] Other than the damage caused by the collision the blue Clio was found to be in good mechanical order and well maintained. What limited defects present could not have contributed to the collision.

Examination of wheels and tyres

[225] The front wheels and tyres were inspected by Richard Vallance and Colum McCarthy, SPA Forensic Scientists at the Scottish Crime Campus, Gartcosh, on 17 July 2015. This examination sought to determine when deflation of the tyres occurred. If deflation occurred prior to the vehicle leaving the M9 that may have contributed to John Yuill losing control of the vehicle and the accident. If deflation occurred after the vehicle left the M9 and was as a result of the accident then it could play no part in the cause.

[226] The driver's side front tyre was identified as a radial, tubeless, uni-directional, Nanking EX-500 185/55R15 81V. The recommended tyre pressure is 32psi.The tyre was fitted correctly to the wheel. It was removed for examination. The valve was capped and did not leak. The valve core was found to be in good condition. It was not possible to conduct an inflation test. A quantity of mud and water was found within the tyre. The inner bead of the tyre was dislodged and the outer bead partially dislodged. The tread was in good general condition with tread depth measured at 4.2mm, 4.8mm and 4.6mm on the outer, central and inner grooves respectively. The legal tyre tread depth for cars is 1.6mm across the central three-quarters of the tyre, (*The Road Vehicles (Construction and Use) (Amendment) (No 4) Regulations 1990*). No defects were found in

the tread. Scrubbing and abrasions were found on the outer tread along with superficial cuts and scores. The outer and inner wall of the tyre was in good general condition and gave no indication of over or under inflated running. The interior of the tyre was in good general condition with no indication of under or over inflated running. There were no plugs or patches on the tyre. The outer bead suffered impact damage on the interior surface exposing a wire. The impact damage to the beads would have caused immediate deflation of the tyre. The inner bead was undamaged.

[227] The driver's side front wheel was identified as a Renault 6Jx15CH4-43, combination hump, 5 spoke alloy. Two areas of impact damage to the outer aspect were found, a split to the lip and an outward leading lateral abrasion on the lip. Two impact deformations to the lip were found on the inner aspect, one of which extended to the wheel wall.

[228] The damage to the driver's side wheel and tyre was caused during accident conditions, that accident was the car leaving the M9 motorway.

[229] The passenger's side tyre was a radial, tubeless, mud and snow, Wanli S-1200 185/55R15 82H make. The tyre was fitted correctly to the wheel. The valve was capped and did not leak. The valve core was in good condition but, due to damage, it was not possible to conduct an inflation test. The tyre was in a generally poor condition. The tread depth was found to be 2.1mm, 0.8mm and 2.2mm in the outer, central and inner grooves respectively. That tread falls foul of the construction and use regulations cited above. There was evidence of over-inflated running on the tread. Damage was evident on the tread in the form of two cuts, two gouges and superficial cuts and scores.

[230] The outer side wall of the tyre was in fair condition with no signs of under-inflated running. There was damage to the outer wall in the form of an 85mm rupture, a gouge mid-wall, five cuts and abrasions and scrubbing. The rupture would have caused instant deflation of the tyre. The inner wall was in good condition and showed no signs of damage or under-inflated running.

[231] The inside of the tyre was generally in good condition. There was no sign of under-inflated running, no plugs and no patches. Vegetation was found within. The liner was cut and cords exposed. The interior shoulders showed rubbing marks consistent with contact with the wheel rims. There was no damage to the beads.

[232] The passenger's side wheel was the same specification as the driver's side. The outer aspect had an impact deformation on the lip, and fresh abrasions.

[233] The damage to the passenger's side wheel and tyre was caused during accident conditions. That accident was the car leaving the M9.

[234] The term '*accident conditions'* could refer to the collision at the locus and the kerbing of the car at Broxden, discussed below. The kerbing did not cause immediate and complete deflation. The rupture would have caused immediate deflation. If that had occurred at Broxden the vehicle could not have travelled a further 30 miles without the tyre disintegrating and the wheel extensively damaged. The kerbing may have caused the tyres to momentarily disengage from the wheel allowing a quantity of air to escape.

[235] Any damage to the wheels and tyres which would cause immediate and complete deflation, such as the rupture, occurred at the time the vehicle left the M9.

Any damage that did not or would not cause immediate deflation may have occurred at either the locus or Broxden.

[236] Mr Vallance accepted, under questioning from Mr McConnachie, KC that over inflated and under inflated running could have an impact on the handling of the car. He could not say whether or not that caused the blue Clio to leave the carriageway. Having considered the evidence, it is highly improbable that it did. I reject the submission that the kerbing of the car at Broxden contributed to the accident.

[237] Taking account of all of the above, I do not, as invited by the Crown, find that a reasonable precaution would have been for John Yuill to have ensured that after leaving Broxden the blue Clio was in a roadworthy condition. Other than the tread of the passenger's side tyre, the car was in good order and roadworthy when it left Broxden.

Examination of the blue Clio's brake lights

[238] In certain circumstances, examination of the brake lights of a car, post collision, can give an indication as to whether or not the brakes were applied at the time of the collision. The bulbs require to be damaged as a result of the collision. If they are and the following is found, that may give an indication that the brakes had been applied:

(i) The presence of, and type of oxides formed on the filaments when the bulb fractures while the filament is hot.

(ii) The presence of glass particles formed when the bulb fractures and the glass comes into contact with the hot filament.

[239] The light unit from the driver's side was damaged to such an extent that no meaningful conclusion could be drawn.

[240] The light unit from the passenger's side was intact. All bulbs were in working order. Ironically, as they were working and undamaged they offered no clue as to whether the brakes had been applied.

[241] In any event, the blue Clio was broadside to the tree line as it crossed the hard shoulder. Even if the brakes were being applied they would have had no effect on the direction of travel or stopped the vehicle in its final journey.

Other relevant information

[242] At 05.31 hours on Sunday 5 July 2015 the blue Clio, driven by John Yuill, is captured on a speed camera on the A9 between Tibbermore and Broxden at an average speed of 91mph. He was driving at this speed after a night consuming alcohol and cannabis. Mr McConnachie KC, took from PC McEwan that his evidence that John Yuill was speeding at the time of the collision was a 'guess'. In the event that it was a guess it was an educated one. This was a single vehicle accident occurring in the absence of any external contributing factors. It was a devastatingly powerful collision between a car and trees. The extent of the damage to the trees and the car is indicative of the force of the collision. PC McEwan said that in his long career as a traffic officer he had witnessed many an aftermath of tree and car collisions but had never seen a tree snapped at its base as he had here. In these circumstances it is reasonable to draw the inference that in the moments before the blue Clio left the carriageway John Yuill was

driving too fast. He was certainly driving too fast to safely execute whatever manoeuvre he was undertaking at the time the blue Clio left the carriageway.

[243] The blue Clio was captured on CCTV entering Broxden at 05.38 hours on Sunday 5 July 2015. Two pieces of evidence which assist in assessing the cause of the collision arise from that footage. Firstly the vehicle is seen to strike the kerb and bounce back at the parking bay it entered. The vehicle struck the kerb at a slight angle causing the passenger's side tyres to take the brunt of the collision. John Yuill did not brake sufficiently. The average speed of the vehicle is calculated at 6 mph. The way in which the car enters Broxden and the parking bay is demonstrative of John Yuill not having full or proper control of the vehicle. Secondly, John Yuill is seen leaving the shop at Broxden. He initially walks away from the vehicle before turning and walking back towards it. During that time he stumbles. Not significantly but sufficiently to indicate that he is not in full control of himself. While in the shop at Broxden witnesses describe his behaviour as hyper and erratic.

[244] John Yuill was habitual user of cannabis and smoked in the order of 30 joints per day. A quantity of cannabis was found in the blue Clio. In the hours before the collision John Yuill had smoked cannabis and drank alcohol. The amount of alcohol and cannabis consumed by him cannot be accurately calculated. The time of his last drink and joint is not known. Toxicology reports confirm the presence of the active drug component of cannabis and its inactive metabolite in his blood. The level of the active component was found to be 26mg/L. That would breach the 2mg/L level specified in the Drug Driving (Specified Limits) (Scotland) Regulations 2019 by some considerable

margin. The Crown submits that a breach of the statutory limit is not necessarily indicative of impairment and that there is no evidence of '*actual impairment*' at the time of the accident. That may, in scientific terms, be so. However taking account of all of the circumstances leading up to the accident, a reasonable inference is that at the time of the collision John Yuill was under the influence of both alcohol and cannabis, or the after effects, to some degree and as a result his ability to drive was impaired.

[245] On Monday 6th July John Wilson was travelling in his lorry on the M9. As he approached the locus he saw skid marks veering sharp left from the M80 to the M9. He described the skid marks as 'readable'.

[246] John Yuill was described by his father as a competent driver. Notwithstanding the fact that he had never passed a driving test, he had been driving for approximately 10 years. During that time he accumulated convictions under the Road Traffic Act 1988. A piece of evidence from Gordon Yuill resonates. His one criticism of his son's driving was that he drove too fast on motorways. He said he had experienced it, didn't like it and had warned him against it. The Crown invited the Inquiry to conclude that John Yuill was not a '*good experienced driver*' and suggests that his experience was that of a provisional licence holder only. There is little evidence available to enable the Inquiry to assess the competence of John Yuill's driving. That he was the holder of a provisional licence is no yardstick by which to measure his competence.

20. Mechanism and cause of the accident.

[247] John Yuill knew the roads from Falkirk to Loch Earn very well. He travelled to the area on a regular basis. He knew motorway network at the locus well. He knew the Divergence and would not have been taken by surprise by it.

[248] John Yuill's standard of driving after leaving the campsite at Loch Earn fell below the minimum standard expected of a competent and careful driver. His driving was such that he presented a serious risk to other road users, himself and Lamara Bell. At the time of the accident John Yuill's ability to drive was impaired as a consequence of having consumed alcohol and cannabis. Whether or not he was, strictly in legal terms, under the influence of either is a matter that cannot be scientifically proved but by inference I conclude that his ability to drive was impaired.

[249] From the available evidence I conclude that John Yuill found himself heading onto the M80 rather than, as intended, the M9 as a result of inattention. At the Divergence he tried to correct his road position while travelling at speed. In doing so he oversteered and lost control of the vehicle. The vehicle rotated approximately 180 degrees anticlockwise through the hard shoulder causing the offside wheels to strike the kerb. The vehicle then travelled 21 meters, broadside, through the trees and dropped 4.3 meters to its resting place at the foot of the embankment.

[250] The cause of the accident was the failure of John Yuill to drive with due care and attention and a combination excessive speed, harsh or oversteering and intoxication caused the blue Clio to leave the carriageway of the M9.

The precautions that John Yuill could reasonably have taken and which, if taken might realistically have resulted in the accident or deaths being avoided.

[251] The first precaution John Yuill could reasonably have taken was not to drive the car. His licence did not permit him to do so unsupervised. Whether supervision would have made him drive more carefully is unknown, but not driving the blue Clio would have avoided the accident.

[252] A precaution, which John Yuill could reasonably have been would have been to have driven the blue Clio to the standard of a competent and careful driver.

[253] A precaution which John Yuill could reasonably have taken would have been to ensure that he was not under the influence of, or the after effects of, the consumption of cannabis or alcohol when driving the blue Clio. That he was physically and mentally in a fit state to drive.

[254] Had John Yuill taken these reasonable precautions, then the accident and in turn his death and the death of Lamara Bell might realistically have been avoided. These are the only precautions that would have realistically avoided the death of John Yuill. Additional precautions in relation to Lamara Bell are considered below.

21. Was Lamara Bell wearing a seat belt?

[255] The question whether or not Lamara Bell was wearing a seat belt at the time of the collision arose.

[256] Robert Findlay, the first person to encounter Lamara Bell, was clear in his evidence. She was wearing her seat belt. He described her as trying to unfasten it. He said that she was: '*More concerned about getting the seat belt off…..she was moving her arms about trying to get the seat belt off.*' He saw the seat belt clipped in place. Mr Findlay's evidence on this matter was not explored in cross examination.

[257] Iain Lockhart remained with Lamara Bell from his arrival until she was taken from the locus. He saw the seat belt was fastened. His evidence on this point was not subject to cross examination.

[258] Mr Findlay's and Mr Lockhart's evidence requires to be assessed in light of the evidence from PC McEwan. From his investigations he was unable to say whether or not the seat belt was fastened at the time of the collision. Evidence such as friction marks on the fabric of the belt or a locked belt mechanism that he would expect to see post collision, if the belt was fastened, were absent. In the absence of such evidence he thought it more likely that Lamara Bell was not wearing the seat belt. In answer to questions from Mr Brown, KC he confirmed that if an eye witness said he saw Lamara Bell trying to remove her seat belt then he would accept that she was wearing it.

[259] Images from the average speed camera on the A9 on Sunday 5 July 2015 show Lamara Bell in the blue Clio wearing her seat belt. Images from the CCTV at Broxden on the same date show her in the blue Clio wearing a seat belt.

[260] Mr Findlay and Mr Lockhart were excellent witnesses and there is no reason to question their reliability when they confirm that Lamara Bell was wearing her seat belt. Mr Findlay was able to confirm Lamara Bell's level of consciousness by the fact that she

was making an effort to free herself from it. Mr Lockhart was in close contact with her throughout her rescue. In all the circumstances I accept their evidence and conclude that Lamara Bell was, at the time of the collision, wearing her seat belt.

22. Disposal of blue Clio

[261] As is standard practice with vehicles involved in fatal road traffic collisions the blue Clio was taken from the locus to vehicle recovery premises on Wednesday 8 July 2015. Although stored in the open air it was, for reasons of privacy, covered with a tarpaulin. It remained there until it was destroyed.

[262] The disposal of the blue Clio, caused Gordon Yuill concern. As a courtesy to him, the Crown led evidence from Inspector Andrew Thomson to explain his decision to release it for disposal.

[263] Mr Yuill spoke to John Ferguson, an Investigator from PIRC, and told him that he wanted the blue Clio independently examined. He was unable to say when this conversation took place. Sadly Mr Ferguson is now deceased. Mr Ferguson's statements confirm that he had a discussion with Mr Yuill regarding the return of his son's personal belongings. No mention is made of a discussion regarding the return of the blue Clio or Mr Yuill's wish for it to be examined.

[264] At 11.00 hours on 18 August 2015 Inspector Thomson and Sergeant Ruth Aitchison met with Gordon Yuill and his family. They were accompanied by John Ferguson. The findings of the collision investigation were discussed with them. At the conclusion of that meeting Inspector Thomson advised Gordon Yuill that the vehicle

would be disposed of once the police investigations were complete. He recalls no request from Gordon Yuill about viewing or disposing of the vehicle. The Bell family advised that they wanted the vehicle disposed of and that a particular scrap yard not be used.

[265] In April 2017, following a review of vehicles held by Police Scotland, Inspector Thomson was asked by OSD Vehicle Recovery East for an update on the need to retain the blue Clio. On 11 April 2017 Inspector Thomson sought advice from COPFS. He received no response. On 16th November 2017, in the absence of a reply from COPFS, he authorised its disposal. He did so for many reasons, summarised as follows:

(i) There were no criminal proceedings arising from the accident.

(ii) The vehicle had been comprehensively photographed and examined at the locus and the recovery yard.

(iii) The examination had described the car as well maintained.

(iv) The families of John Yuill and Lamara Bell were aware of the intention to destroy the vehicle.

(v) The vehicle was still contaminated.

(vi) After the length of time the vehicle had been exposed to the elements any further examination would be of little value.

[266] It may have been that Gordon Yuill would have had the vehicle independently examined. The destruction of the vehicle deprived him of that opportunity. As submitted by Mr McConnachie, KC in cases where criminal proceedings are to be taken the vehicle will not be released until the defence have had the opportunity to do so.

However, the vehicle had been in the possession of Police Scotland from the date of the accident until its destruction in January 2018, a period of more than two years. At no time during that period did Mr Yuill, or anyone acting on his behalf ask to view it or that it be made available for examination. The opportunity to have an independent expert review the collision investigation and subsequent report was not taken.
Mr McConnachie, KC took the opportunity to cross-examine Richard Vallance, PC Richard McEwan and Inspector Andrew Thomson.

[267] Inspector Thomson accepted full responsibility for authorising the vehicle's release and destruction. He did so without further reference to Gordon Yuill, family liaison officers, COPFS or PIRC. He did so for good reason and in good faith. It would however have been wiser for Mr Yuill's permission to have been sought prior that decision being made.

[268] Ultimately the blue Clio was destroyed and a Certificate of Destruction issued by DVLA on 29th January 2018.

23. Family Visit to the locus and debris.

[269] On 5 July 2016 members of Lamara Bell's family returned to the locus to mark the anniversary of her death. They were distressed to discover that remnants of the blue Clio remained there. That should not have happened. Once the vehicle was recovered, the locus should have been carefully searched and all parts of the vehicle removed. Police Scotland recognised the distress caused to Lamara Bell's family and apologised to

them. On Friday 8 July 2016 Operational Support Division carried out a search of the locus and recovered and removed the last remaining parts of the blue Clio.

24. The reform of Police Scotland's Contact, Command and Control System.

[270] Police Scotland's Contact, Command and Control Division ('C3 Division') is commanded by a Chief Superintendent overseen by an Assistant Chief Constable. The ACC reports to the Deputy Chief Constable for Local Policing.

[271] C3 Division receives communications from members of the public requiring either information or assistance from Police Scotland. The public may contact Police Scotland using the emergency 999 number or the non-emergency 101 number. These calls can range from nuisance or trivial to the need to control a major incident. Once a call is received, the appropriate response is determined. That response is determined by a number of factors and in particular the grading of the call.

[272] Calls, from whichever number, are received and dealt with at Service Centres and ACR. The Service Advisers or call-handlers assess the requirements of each caller to determine the appropriate response. The effectiveness of the service Police Scotland can offer the public is dependent on the effectiveness and efficiency of its Service Centres and ACR. C3 Division is the nerve centre of Police Scotland. Any reform of C3 Division must be undertaken and planned with great care, strong management and clear lines of communication.

[273] Police Scotland, the single, national police force in Scotland, came into being under the 2012 Act on 1st April 2013. On the same date, the 2012 Act established the

Scottish Police Authority ('SPA') for the governance, oversight and administration of the police service. The SPA was set up to scrutinise Police Scotland, hold the Chief Constable to account and to keep the policing of Scotland under review. The SPA is responsible for monitoring police performance and does so at regular public meetings. The SPA is independent of both the Scottish Government and Police Scotland.

[274] Prior to the establishment of Police Scotland, policing was conducted by eight separate, or legacy forces:

(i) Central Scotland, Dumfries and Galloway.

(ii) Fife.

(iii) Grampian.

(iv) Lothian and Borders.

(v) Northern.

(vi) Strathclyde, and

(vii) Tayside.

Each of the legacy forces operated its own contact, command and control centres.

[275] In January 2014, C3 Division was made up of 10 ACR and 9 Service Centres operating from 11 locations in Aberdeen, Dundee, Dumfries, Bilston Glen, Glenrothes, Inverness, Motherwell, Glasgow Govan, Glasgow Pitt Street and Stirling. A further seven mothballed sites were capable of being used in the event that any of the operational sites were lost.

[276] Once established Police Scotland constituted the second largest police force in the UK after the Metropolitan Police Service, in terms of officer numbers. It is by far the

largest police force in the UK in terms of its geographical area of responsibility. The scale of C3 Division is best highlighted by considering its statistics. As at early 2014 C3 Division handled approximately 600,000 emergency 999 calls and 3.6 million non-emergency 101 calls per annum through the existing sites. Its work force comprised 1,495 personnel made up of 362 police officers and 1,333 civilian staff. The total budget for the C3 Division amounted to £56 million per annum.

C3 Division remodelling

[277] Prior to the creation of Police Scotland the Association of Chief Police Officers for Scotland (ACPOS) identified a variance in call handling across Scotland. The ACPOS Police Reform Team determined that C3 Division should support policing operations nationally to ensure that specialist services and support could be deployed to deliver the most effective response to policing and emergency needs. As each of the legacy forces had its own system for dealing with contact from the public there was no uniformity in either process or technology. The legacy systems did not communicate with each other. That had the potential to cause a number of problems for a unified police force. For instance smaller control rooms could become overwhelmed if a number of calls came in about a single incident or a series of incidents. The co-ordination of policing across the C3 Division was problematic until a 'virtualised' service was developed.

[278] A significant problem for Police Scotland was that access to advanced technology designed to support call handling was not uniform. Some of the existing sites did not have the benefit of a Customer Relations Manager ('CRM'). Those that did, did not

operate the same CRM. In the West the CRM system was ASPIRE. The East CRM was VANTAGE. Stirling and Glenrothes operated without a CRM.

[279] In May 2013 Police Scotland established a Contact, Command and Control Integration and Remodelling Project Board ('the Project Board'). At inception the Project Board comprised Assistant Chief Constable Andrew Cowie as Executive Lead and Senior Responsible Officer, Assistant Chief Constable Mike McCormick as Business as Usual lead, Superintendent David Tonks was Vice Chair and Change Manager. Chief Superintendent Val Thomson, then C3 Divisional Commander, provided a link between the Project Board and C3 Division. From June 2013 ACC Mike McCormick took over ACC Andrew Cowie's role. Elaine Malcolm, a civilian employee, was Human Resources lead.

[280] The remit of the Project Board was to oversee the reform and restructure of the C3 Division ('the C3IR Project'). Its terms of reference were issued on 22nd April 2013. The purpose of the C3IR Project is stated as; *'Police Scotland is embarking on an unprecedented level of organisational and structural change which is both challenging and achievable. To ensure success and to continue to keep people safe, a portfolio management approach has been adopted to best deliver the future needs and requirements of the Service.'*

[281] The stated objectives of the C3IR Project were, amongst other things:

(i) To drive the programme forward and deliver outcomes for the benefit of the service.

(ii) To oversee the design and implementation of measures within Police Scotland, necessary for the transition of the current structure to a future

integrated and remodelled structure and to ensure progress is made in a timely fashion.

[282] At the inaugural meeting of the Project Board on 1st May 2013, while the timeline for delivery was still to be established, ACC Cowie advised that an *'aggressive timeline can be anticipated'*.

[283] In terms of paragraph 11 of the remit the 'Success Criteria' was said to be, amongst other things; *'The successful transition of the C3 Division into an integrated structure whilst 'Keeping People Safe and maintaining excellent policing services in the communities of Scotland.'*

[284] The Project Brief was issued in May 2013. The Brief identified primary risks with the C3IR Project, in particular the need to keep people safe from harm while it was implemented.

[285] Following consultation with stakeholders and informal meetings between senior officers referred to as 'Star Chamber' meetings, on 30th January 2014 Assistant Chief Constable Mike McCormick presented a paper entitled; *'Contact, Command and Control Proposed Strategic Direction'* ('the Strategic Paper') to the SPA.

[286] The Strategic Paper proposed the closure of a number of smaller control rooms and Service Centres, and the timeline for doing so. The rational of the paper was that fewer but larger integrated control rooms all using the same ICT systems would improve the efficiency and effectiveness of the C3 Division, or as it stated; *'The creation of a single service gives us a unique opportunity to make improvements on a national basis to deliver a truly integrated policing service that is fit to serve the public in the 21st century.*

Technology developments mean that we can answer calls from anywhere in the country and ensure that local knowledge is available to the call taker. We can identify at the touch of a button, where all our resources are and who is the most appropriate to attend an ongoing incident. We can put other measures in place to deal with a caller's issue at the first point of contact and prevent unnecessary attendance of officers at a location. Most importantly we can deliver a consistent highly effective, professional policing service to all our communities, no matter where they are located. A significant benefit of the context provided by policing having become a single service, is that these significant improvements can be implemented in a way which also delivers significant efficiency savings'.

[287] What was proposed was an integrated tripartite call handling system using the AVAYA telephone system, ASPIRE CRM and STORM Command and Control ('the tripartite system'). The tripartite system would operate from a sub-divided C3 Division consisting of the Service Centre, the Public Assistance Desk ('PAD') and ACR, all under the one roof. The intention of Police Scotland was that all call handlers would use the tripartite system whatever Service Centre they may be in with each Service Centre capable of handling calls from wherever they came.

[288] On 30th January 2014, the SPA, approved Option 3 of the Strategic Paper, the preferred option of the Project Board. This involved the restructuring of C3 Division whereby the 11 existing sites and the mothballed sites were reduced to 5, comprising:

(i) West Command Area Control (Govan and Motherwell combined ACR).

(ii) East Command Area Control (Bilston Glen ACR).

(iii) North command Area Control (Dundee ACR).

(iv) National Command Area Control (Inverness ACR).

(v) A National virtual Service Centre using the sites at Govan, Bilston Glen and Motherwell as a single site providing back up for other sites.

[289] What was to be created was a national platform for contact, command and control with the tripartite system used throughout. The introduction of the tripartite system necessarily involved new IT systems and the reorganisation of staff across C3 Division.

[290] Option 3 involved restructuring C3 Division in a six stage process to be concluded over a two year period as follows:

Stage 1 - The relocation of the Dumfries ACR to Glasgow Pitt Street with a completion date of April/May 2014

Stage 2 - The delivery of fully integrated systems and procedures across the Govan, Pitt Street, Motherwell and Bilston service centres and ACR. This was a significant and complex undertaking involving the removal of the Bilston Glen switchboard and the re-modelling of its call handling. It was planned to be completed by September 2014, an ambitious target which was not achieved in that time-frame.

Stage 3 - The relocation of the Stirling service centre and ACR to Bilston by the end of December 2014.

Stage 4 - The transfer of the Glasgow Pitt Street service centre and ACR to Govan, with a target date of end March 2015. The closure of Glenrothes and transfer of operations to Bilston by 17 March 2015.

Stage 5 - The relocation of the Inverness ACR to Dundee and its service centre to the National virtual centre, with a completion date of end September 2015.

Stage 6 - The relocation of the Aberdeen service centre to the National virtual centre and the ACR to Dundee. Target date end December 2015.

[291] It was anticipated that the rolling programme of procurement and implementation of the ICT systems would be completed by end June 2016. That meant, so far as Bilston was concerned, the West ASPIRE being operated until the updated systems were installed in 2016.

[292] A major part of the C3IR Project was about saving money. It was estimated that the C3IR Project would see the release of between 155 and 212 Police Scotland staff posts with associated savings estimated at between £4.28 million and £5.88 million per annum. Additional savings were anticipated in the order of around £900,000 per annum following the rationalisation of the ICT systems. Further, unquantified, savings were expected from the release of the disused property.

[293] The area of the C3IR Project that is of interest to this Inquiry are the plans for Bilston. In April 2013 the East sub-division control centres were located at Bilston, Glenrothes and Stirling. In terms of Stage 3 of the C3IR Project, Stirling was to close and relocate to Bilston by December 2015. In terms of stage 4, Glenrothes was to close and relocate to Bilston Glen by 17 March 2015. The appropriate allocation of resources, in other words people, for Bilston was a priority for the Project Board. The responsibility for that allocation fell to the C3 Resource Management Unit ('RMU'). Using forecasting and scheduling tools RMU assessed that 160 call handlers would be required to meet

anticipated demand. That figure was to be achieved incrementally by way of staff relocation and recruitment.

[294] The number of call handlers at Bilston was expected to rise to 120 following the closure of Stirling, increasing to 140 on the closure of Glenrothes, reaching 160 by December 2015. To achieve these numbers required, in part, a number of existing call handlers to relocate from Stirling and Glenrothes to Bilston. The hoped for relocations did not transpire. When Stirling closed 13 existing call handlers relocated. As at February 2015 there were 105 call handlers at Bilston, a shortfall of 15 from the planned 120. On closure of Glenrothes 4 call handlers transferred. As at 17 March 2015 there were 109 call handlers at Bilston, a shortfall of 31 from the planned 140. These numbers were augmented by 21 call handlers who, having accepted voluntary redundancy, agreed to stay on until October 2015 and were available to assist at Bilston until then.

25. Identified Risk – Risk 6

[295] The C3IR Project was by any commercial standards a complex exercise. That was recognised by Police Scotland in retaining Sabio Consultancy, a company specialising in advice to contact centre providers. After examining C3 Division's corporate structure and core functions it reported on 30th January 2014. That report identified the potential for loss of experienced staff as a result of an inability or unwillingness to relocate. Amongst other things, Sabio recommended that 3C Division strengthen its monitoring and quality assurance processes and:

(i) Introduce a robust quality monitoring process across all the service centres.

(ii) Create a planning model for training to assess the correct level of training required.

[296] In line with Health and Safety legislation and project management practice the Project Board assessed risk and implemented a Register of Risks ('the risk register') that the C3IR Project might face. This allowed the Project Board to identify and document risk, assess its severity and implement mitigatory controls. The probability of risk arising, the impact of that risk and any mitigatory factors were important to ensure the safety of the C3IR Project and the public as it was rolled out. The Project Board sought to identify real rather than theoretical or hypothetical risk for analysis.

[297] An identified risk was assessed on the likelihood of occurrence and the impact that occurrence would have. The Project Board set a risk scale of Low (1-5), Medium (6-9), High (10-19) and Very High (20-25). Any increase or decrease in a risk score was determined by the Project Board based on current information available to it.

[298] A key risk identified with the C3IR Project was that the number of staff needed at Bilston may not be achieved or at least not in the time line for the closure of Stirling and Glenrothes. As early as the Project Board meeting of 26th June 2013 that risk was identified. The wide geographical dispersal of the proposed streamlined sites was identified as a hurdle in retaining and employing experienced staff. As it proved,

Bilston was not an attraction to many existing staff. This risk, referred to as 'Risk 6' was, at 26th June 2013, assessed as Medium.

[299] Risk 6 was identified early, and it would appear considered to some degree by the Project Board, Senior Leadership Board ('SLB') and the SPA as the C3IR Project evolved. How that risk was managed, or otherwise, led to the arrival of Brian Henry at Bilston in June 2015.

26. Management of Risk 6

[300] Joint Minute of Agreement number 1, the report prepared by Mr Sylvester-Evans and the productions spell out in detail the minutes of the meetings of the Project Board, SLB and the Gold Group ultimately set up to address Risk 6 . I do not repeat these at length, but set out a summary of some meetings up until the return of ACC Val Thomson to Bilston in April 2015.

[301] The SLB comprises the Chief Constable, Deputy and Assistant Chief Constables supported by civilian staff. It is chaired by the Chief Constable. The SLB meets monthly to deliver leadership, determine Force policy, strategy and direction. It drives the Force Strategic Plan, considers and agrees major decisions on new or emerging matters and provides a forum to voice key governance issues. Minutes of all SLB meetings should be kept and accurately recorded. Minutes of open sessions are published on the Police Scotland website. Minutes of closed sessions are classified as restricted and deemed unsuitable for publication. At times of increased change within the Force, STAR Chamber meetings, comprising members of the Force Executive Team and chaired by

the Chief Constable take place. A rolling STAR Chamber Master Action Log is maintained.

[302] The SLB had an overview of the C3IR Project from its inception. It was briefed on its progress at regular intervals by ACC Michael McCormick, a member of the SLB by virtue of rank. It was not always provided with accurate and relevant information in relation to Risk 6 or the assessed risk score. It was not always provided with an accurate picture of how Bilston was performing. It was not always provided with accurate information as to the effect the lack of call handlers had on performance and morale. That is highlighted by reference to the following:

(i) At the meeting on 18 June 2014, the SLB was updated on the C3IR Project. No staffing issues were documented.

(ii) On 16th July 2014, the SLB was updated by ACC McCormick, and advised that Stage 2 ICT timescales were proving difficult as a result of difficulty recruiting skilled staff. No mention of Risk 6 is minuted.

(iii) On 17 September 2014, the SLB was advised by ACC McCormick of a notable shortfall in suitably trained staff at Bilston and in particular the back shift. What were described by ACC McCormick as 'mitigatory' actions were noted. The SLB granted permission for the recruitment of temporary staff.

(iv) On 23 October 2014, Deputy Chief Constable Rose Fitzpatrick, a member of the SLB, presented an update paper on the C3IR Project. Approval was sought for measures to be implemented in preparation for the closure of Stirling. It was agreed that further discussion would take place at a Star Chamber meeting on

24th October 2014. An action plan, (77.14), noted that Deputy Chief Constable Fitzpatrick was to ensure that *'…a discussion took place on the transfer of C3 business from Stirling to Bilston Glen using a Flexible Deployment Model and other opportunities.'* The Crown submits that it is clear that the SLB considered the C3IR Project at this meeting. It did, but in what detail is difficult to gauge from the minutes. What it understood the Risk 6 score to be is unclear.

(v) At the SLB meeting on 8 December 2014, it is noted that ACC McCormick provided a verbal update and that action plan 77.14 was '*complete*'. He highlighted the need for more staff at Bilston and advised that this was being worked on. No actions or decisions of the SLB are recorded in relation to the C3IR Project. The assessment of Risk 6 is not noted.

(vi) At a STAR Chamber meeting on 23rd December 2014, it was noted that discussions were ongoing to define numbers required across C3 Division.

(vii) At the SLB meeting on 21st January 2015, ACC McCormick presented a paper on the progress of the C3IR Project. He confirmed that recruitment was ongoing to fulfil the staff compliment at Bilston. It was not. It was clear at this stage that a number of staff at Stirling and Glenrothes had opted for redundancy rather than transfer to Bilston.

(viii) At the SLB meeting of 18 February 2015, ACC McCormick presented an update paper on the progress of the C3IR Project. The minutes of that meeting are sparse. In his oral evidence ACC McCormick said that there would '*absolutely*' have been discussion about the progress of Bilston and that

recruitment was ongoing. This meeting took place prior to an Options Paper prepared by Elaine Malcolm highlighting the increasing difficulties facing Bilston and a variety of options to mitigate Risk 6. There is nothing in the minutes which confirms that the SLB had an accurate picture of the state of Bilston at this time.

(ix) On 18 March 2015, the SLB was updated by ACC McCormick, in terms of a further Briefing Paper authored by him. The SLB was made aware of the challenges around performance levels as a result of problems recruiting, inducting and training staff. A range of actions were said to be being implemented to address the problem including the redeployment of Police personnel, overtime payments, the use of PAD officers and transferring calls across the virtualised service centre.

(x) At the meeting on 18 March 2015, ACC McCormick was asked by a board member how likely it was that staffing issues would be resolved in 6 weeks. He confirmed that they would be resolved in that timescale, but that the requisite staff may not be fully trained at that point. There was at that time no ongoing recruitment process.

(xi) The following is minuted from the above meeting; '*Performance has been protected for the 999 service to ensure that standards are met on emergency matters and 101 callers are prompted to switch to 999 at 30 second intervals whilst they cue* (sic) *for a reply. Service standards are steadily improving as the impact of the above measures are embedding.*' That statement cannot be reconciled with the fact that on one day in

that month Bilston's performance was sitting at 20% before assistance from Govan brought it up to 70%. It cannot be reconciled with what ACC Val Thomson discovered on taking over from ACC McCormick.

[303] The Crown submits that the SLB minutes are less informative than they might be in relation to Risk 6. Of that there is little doubt. That has to be balanced with the oral evidence of ACC McCormick that the risk was always discussed at SLB meetings. He goes further and says that the SLB were always kept fully informed on the progress of the C3IR Project and the problems with recruitment. That contention is not supported by the SLB minutes.

[304] The SLB had the papers authored by ACC McCormick and it knew as at 23rd October 2014 that the number of staff at Bilston was an issue, as was recruitment. That was confirmed in the updated Briefing Paper prepared for the SLB meeting on 18 March 2015. However, the SLB were not routinely provided with the level of risk, in numerical terms, attached to Risk 6 and the detrimental effect that was having on performance and staff morale.

Project Board meetings

[305] The Project Board were aware of the problems facing Bilston. At its meeting on 19th August 2014 it was noted that there was a significant number of vacancies particularly with the back shift. It was noted that Bilston was sitting well below its call handler target and receiving assistance from staff in the North. Although handlers did not have personal targets they were expected to deal with calls effectively and

efficiently. Police Scotland had a grade of service whereby 90% of 999 calls were expected to be answered within 10 seconds and 101 calls answered within 40 seconds.

[306] At the Project Board meeting on 16th September 2014 the level of performance at Bilston was discussed and considered to be a problem. The reluctance of experienced staff willing to transfer to Bilston was highlighted. It is noted that '*every effort*' was being made to fill the vacancies. The Risk 6 score was raised from 9 to12, High. By this time ACC McCormick had stepped back from operational duties to concentrate on the C3IR Project and to address its ongoing problems.

[307] The Project Board again met on 22nd October 2014. It was, again, acknowledged that the level of vacancies at Bilston and a lack of recruitment were the most significant problems affecting performance. The risk register did not identify mitigating measures. The Risk 6 score was increased to 16, High.

[308] There is a passage in the minutes of the meeting on 22nd October 2014, which indicates that communications between the Project Board, via ACC McCormick, and the SPA were not always candid. What is noted is the following; "ACC McCormick advised Board members that an update paper has been prepared for the SPA meeting (tomorrow). He went on to advise that our call taking performance data is likely to come up for discussion, with performance down in a number of areas, though not breaking any targets. Therefore there is a danger that presenting an unduly positive picture to the SPA will be picked up by the media. MMc acknowledged that the current levels of vacancies is the most significant factor behind the current levels of performance. He went on to ask that the C3 area Superintendents reassure staff that

recruitment is being addressed". That statement indicates a lack of candour regarding the extent of the problems facing Bilston. Aside from the fact that there was a duty to accurately reflect the state of the C3 Division to the SPA as opposed to an *'unduly positive picture'* that statement puts in context the beleaguered state of Bilston as at October 2014. It was understaffed. The staff there were overworked. Performance levels had dropped. The morale in the Service Centre was poor and it was barely coping on a daily basis. All of that information and the assessed level of Risk 6 should have been spelt out in stark, unadulterated terms to the SLB and the SPA.

[309] The Project Board met again on 16th December 2014. For what is described as a '*shortage of time*' Risk 6 was not discussed. Mitigatory measures were discussed. ACC McCormick undertook to discuss the risk register out with the meeting. The risk score remained at 16. ACC McCormick is minuted as informing Board members that an update paper had been prepared for the SPA meeting the following day and that; '*No particular challenges are anticipated'*. If the SPA were aware of the extent of the problems facing Bilston at that time, significant challenges should have been anticipated. AVAYA and ASPIRE systems were noted as working effectively. That is entirely at odds with what the call handlers and supervisors were experiencing at Bilston.

[310] When interviewed by PIRC, ACC McCormick was unable to recall why the risk register was taken '*off table*' at the December 2014 meeting. It had happened before and when it did, it was his practice to review the assessment of Risk 6, approve it or otherwise and present any update at the following meeting. He informed PIRC investigators that the risk register always featured late on the Project Board agenda and

that due to pressures of business and time occasionally led to consideration of it being deferred.

[311] On 21st January 2015 ACC McCormick's update Briefing Paper to the SLB confirmed that many of the staff at Stirling and Glenrothes had accepted voluntary redundancy rather than relocate to Bilston, but that recruitment was ongoing. It was not.

[312] The briefing paper to the SLB on 18 February 2015, prepared by ACC McCormick, noted that Stirling had successfully transferred to Bilston and that the transfer of services from Glenrothes to Bilston was at an advanced stage. The recruitment process was said to be ongoing. It was not. The briefing paper expressed no concerns over staffing levels. Laura Henderson the Service Centre Manager at Bilston recognised, in January 2015, that call handlers had to be recruited urgently. Elaine Malcolm was acutely aware of the effects the shortfall in staff was having on Bilston and brought it home to senior officers at Bilston in clear terms.

[313] Elaine Malcolm provided ACC McCormick and CS Craig Naylor in advance of a meeting of the Project Board on 25 February 2015 with a paper entitled *'C3 East Resourcing – Options Paper'*, prepared by the Business As Usual ('BAU') team. The paper highlighted the challenges facing Bilston and a range of mitigatory options. That paper presents a picture, as at 25 February 2015, contrary to the information available to the SLB and the SPA. What can be taken from that paper is as follows:

(i) Towards the end of the redundancy consultation period, 27 November 2014, a need to recruit externally to ensure sufficient numbers at Bilston was identified.

(ii) While external recruitment had been ongoing for some months, no new recruits had been employed.

(iii) The scale of the resourcing gap was more significant than expected and was impacting adversely on performance and morale at Bilston, which was expected to worsen on the closure of Glenrothes.

(iv) Five existing Bilston call handlers had been successful in their application for posts in the ACR, further reducing the Service Centre complement.

(v) All new recruits would require extensive training before being fully deployed in the Service Centre.

(vi) The majority of the gaps were in the back shift.

[314] The paper detailed the mitigatory steps already taken, summarised as follows:

(i) An escalation of the recruitment process with offers of employment being made on condition of suitable references and medicals.

(ii) A review of the induction and training programmes.

(iii) Aligning daily resources to meet operational demand to include shift variations.

(iv) A review of skills and responsibilities across the Service Centre, PAD and ACR to maximise capacity.

(v) The use of all technical support available to enhance service delivery and support from West Service Centre.

(vi) Daily meetings with staff to bolster morale and performance.

(vii) The use of overtime.

[315] The paper stressed, and Ms Malcolm clearly understood, that the identified mitigatory provisions were not sufficient to overcome the threat to morale and performance and warned that all possible options were needed to *'minimise or completely alleviate the risks'* attached to the shortage of staff. The following options were identified as open for discussion at the Project Board meeting on 25 February 2015:

(i) Allowing overtime for staff within Bilston and elsewhere to include trained staff on a voluntary overtime basis.

(ii) Retaining Glenrothes call handlers due to relocate to Dundee until Bilston achieved its full complement of staff.

(iii) Using supernumery staff from Bilston who had yet to secure other employment.

(iv) The use of recently retired officers. It was thought that the training requirements of these officers would be less given their background.

(v) Maximising staff capacity.

(vi) The use of skilled resources from out with C3 Division on a short-term basis until the recruitment process was complete. These officers are referred to as Divisional officers.

[316] The use of option (vi) is what ultimately led to Brian Henry arriving at Bilston Glen.

[317] On 25 February 2015 the Project Board met. It had the benefit of the BAU paper. The work load, performance levels and morale were anticipated to suffer further once Glenrothes closed on 17 March 2015, accordingly the Risk 6 score was increased from 16 to 20, Very High. Following that meeting mitigatory and contingency measures were implemented in the form of:

(i) Payment of staff overtime.

(ii) Mandating overtime for police officers.

(iii) Asking staff who had taken voluntary redundancy to stay on.

(iv) Seconding control room staff from Stirling.

(v) Transferring calls to Motherwell or Govan, and

(vi) Filtering calls for lost property, custody enquiries and internal calls.

[318] ACC McCormick informed the meeting that at the SLB meeting the previous day, although he had prepared an update paper, the SLB had preferred a '*brief update as part of the Chief Constable's wider update to the board*'. He received notification in advance of the meeting that the SLB wanted specific detail around staffing numbers and performance. ACC McCormick noted that the Project Board continued to have a good relationship with the SPA and there was a '*lot of positivity*' around the significant work undertaken by all concerned.

[319] On 18 March 2015 ACC McCormick's update Briefing Paper for the SLB noted that the biggest challenge Bilston faced in meeting call handling targets was the

recruitment, induction and training of staff. A large number of applicants were sought. Identifying applicants with suitable skills and vetting delays added to the difficulty. The paper advised the SLB that staff at Bilston using the tripartite system were unfamiliar with it. Throughout March and April 2015 the Risk 6 score remained at 20, Very High. If the SLB had taken cognisance of the update Briefing Paper it must have been aware that Bilston was not performing as it should. The SLB were however led to believe that recruitment was ongoing when in fact it had ground to a halt.

[320] Throughout March and April 2015, Risk 6 remained at 20, Very High. It is unclear from the minutes of the SLB whether or not it was made aware of that grading. It seems from the events that followed the appointment of ACC Thomson that both the SLB and the SPA, given their reactions, were in ignorance of the true extent of the problem facing Bilston.

Observations on Minutes generally

[321] The purpose of minutes of meeting is to provide an accurate and impartial record of what took place at the meeting. The Crown submit that the minutes of the SLB are less than helpful or informative. The same criticism can be made of some of the Project Board minutes. The content of these minutes should enable the reader to understand what progress is being made in the implementation of the C3IR Project, what decisions are being made and by whom and precisely what the next steps are. The Project Board and SLB minutes do not do this. Some give a misleading picture of what is going on at Bilston. Some are self-serving and seem designed to protect the Project

Board or at least ACC McCormick from criticism or scrutiny. It is not possible, on a simple reading of the minutes, to measure what progress was being made in the effort to mitigate Risk 6. In short, they are not sufficiently detailed to provide the reader with a true picture of what is happening.

Overview and assessment of the management of Risk 6

[322] The risk that there would be insufficient staff at Bilston on the closure of Stirling and Glenrothes was identified as early as June 2013. From June 2013 through to 27 November 2014 the need to recruit more staff is a feature of the Project Board meetings as is the use of mitigatory factors to alleviate the stress on Bilston while staffing levels are achieved. None the less over that time recruitment was poor.

[323] There was no ongoing recruitment from January 2015 until April 2015, when ACC Thomson took over from ACC McCormick. That period is described by Mr Sylvester-Evans as a '*hiatus*'. Laura Henderson did not think that senior management fully understood what the position on the ground was and that the organisational structure was unclear and confused.

[324] The Crown submitted that as at the end of March 2015 there remained significant staffing shortfalls which in turn affected performance. That is clearly so. It submitted that the staffing shortfalls had not been adequately managed to that point. That is clearly so. It follows then that the success criteria of the C3IR Project in maintaining excellent policing services and protecting the public was not being met. Up to the point that ACC Thomson and CS Speirs assumed control much more should have been done

to employ staff at Bilston. The last recruitment drive was in January 2015 and with little success. Ms McCall, KC submits that a number of factors contributed to that, which were out of the control of Police Scotland. She lists the following:

(i) The low number of applicants.

(ii) Only temporary posts were permitted to be advertised.

(iii) The unwillingness of applicants to transfer to Bilston.

(iv) The length of time it took to vet applicants and the length of time it took to train successful applicants.

I am not persuaded that all were out with the control of Police Scotland. These are factors that many organisations face when recruiting. Police Scotland must have been aware, and if not should have been, that quite apart from the numbers needed applicants would need to be vetted and trained. That the posts advertised were restricted to temporary posts is an oddity that I fail to understand.

[325] Once ACC Thomson took control in April 2015, significantly more effort is made to recruit staff and ultimately Divisional officers. That recruitment process is accelerated by a decision made by Inspector Michaela Kerr. Alongside recruitment of Divisional officers efforts were being made to recruit core staff and in some innovative ways including:

(i) Open days.

(ii) Recruitment drives at Universities and colleges.

(iii) Friends and family recruitment.

(iv) Social media campaigns and '*pop up*' recruitment shops.

[326] What led to the hiatus between January 2015 and April 2015 is not obvious from the evidence. Over that period of time the efforts to recruit staff had effectively ground to a halt. That left Bilston in a precarious state and not best placed to protect the public.

[327] Mr Sylvester-Evans described the C3IR Project as a major structural and complex reorganisation of the Service Centres. He anticipated that such a project would experience problems trying to maintain performance while recruiting staff and restructuring IT systems. His analysis is that Police Scotland did not fall short in the planning and oversight of the C3IR Project. It identified the dangers that Risk 6 presented and reacted to resolve or mitigate them. That assessment is fair looking at the overall picture but is generous in relation to the period of the 'hiatus', during which time no effort is made to recruit staff at a time when it was patently obvious significant assistance was needed.

27. Systems in operation at Bilston as at January 2015.

[328] Bilston is a purpose built facility and Police Scotland Service Centre, configured on an open plan basis with three defined areas:

1. The Service Centre accommodates call-handlers seated at their individual workstations, formatted in groups of twelve. Team Leaders oversee and monitor the work of the call handlers. The Team Leader is positioned apart from, but close to, the group they lead. Team Leaders have their own work station and monitor the call handler's work by dipping in and out of calls. At the work

station the call handler operates two screens. The left hand screen is ASPIRE. The right hand screen is STORM. The telephone system is AVAYA.

2. The Area Control Room accommodates staff trained to receive STORM incidents and to action the appropriate police response. The controllers in the ACR ensure that the most suitably skilled and equipped police resource is tasked to deal with any given incident and within an appropriate timeframe.

3. The Public Assistance Desks ('PAD') were staffed by police officers who offer general advice or assistance to callers, routed to them from the switchboard, where no physical police presence is necessary.

[329] Call handlers operated three shifts at Bilston, each shift lasted eight hours. The day shift from 7.00am until 4.00pm. The back shift started at 3.00pm ending at midnight. The night shift commenced at 10.00pm until 7.00am. The overlap between the back and night shift was designed to cover peak times.

[330] Members of the public contact Police Scotland using two numbers, the 999 emergency number or the non-emergency 101 number.

[331] Using the 101 number the caller is connected to Police Scotland directly and given four automated options:

(i) Lost property.

(ii) Custody enquiries.

(iii) To speak to a particular person or department.

(iv) To hold for a service adviser.

[332] 101 calls are transferred to the first available call handler. The call handler can transfer the call between the four options and upgrade it to the status of a 999 call.

[333] If the 999 number is used the caller speaks firstly to a British Telecom operator who then directs the call to the emergency service requested i.e. Police, Fire or Ambulance.

[334] Using either number the caller, makes contact with Police Scotland and speaks to someone in a Service Centre. This is the '*Contact*' in C3 Contact, Command and Control Division. Core call handlers employed by Police Scotland are civilians rather than police officers. At Bilston 999 calls were routed to the first available call handler trained and permitted to respond to 999 calls

The tripartite system AVAYA, ASPIRE and STORM

[335] The tripartite system of AVAYA, ASPIRE and STORM was the system that Police Scotland expected all call handlers core or non-core to be trained in and to operate at all Service Centres. That expectation may have materialised if senior officers and civilian managers understood that AVAYA and ASPIRE were not different names for the same thing, and understood their different functions. That lack of understanding led to confusion as to what was expected by way of qualification for, and the training of volunteer Divisional officers working at Bilston

ASPIRE

[336] ASPIRE is the CRM currently operated in C3 Division. It is an upgrade of the system operated in 2015. The upgrade to the system will be considered later. In 2015, when dealing with calls, core staff, operated ASPIRE. At that time, ASPIRE was the CRM operated in legacy Strathclyde and the CRM to be rolled out across C3 Division once the C3IR Project was complete.

[337] At the start of a shift the call handler logged onto the system. If a caller had contacted Police Scotland before, ASPIRE automatically populated the caller's details from its data base. It populated the caller's name, telephone number, address and a summary of previous calls made to police Scotland from that device. It displayed the call history associated with the caller's number, details of other persons who have made calls from that number and related incidents. Thereafter the call handler inputted the current information onto the system.

[338] ASPIRE provided an A-Z of prompts and questions allowing the call handler to assess and grade the call for prioritisation. For example if the call related to a missing person the call handler had a series of prompts and questions that assist the assessment process. These prompts and questions were a tool enabling the call handler to ensure that as much information as is necessary was obtained from the caller. Call handlers were also expected to use their own initiative in obtaining relevant information from the caller.

[339] ASPIRE enabled the call handler, once they typed up the callers details and the information obtained including the grading, to automatically transfer it onto STORM

and transfer it to the ACR. That was done by pushing the '*submit*' button. Once transferred to the ACR, it was the responsibility of the controller to allocate the appropriate police response.

[340] ASPIRE had two important built in safeguards. Firstly, if a call handler created a STORM incident but did not transfer it to the ACR that showed up on the supervisors filter, enabling the supervisor to question the call handler and ensure that it was not an oversight. Secondly when using ASPIRE the call handler could not take another call until they completed the current call.

AVAYA

[341] AVAYA is the trademark name of the telephone system that routes calls to available advisers. It is the telephone system currently in use at Police Scotland and in use in 2015. It is a manual telephone system, it has no database. It can be used independently of ASPIRE. Core call handlers were instructed to use it when ASPIRE was not operational. Call handlers logged on to the system. Unlike ASPIRE it did not automatically populate the caller's details. The call handler was required to do so during the call if, able to talk and type at the same time, or note the details in a Pot Book and manually enter them at the end of the call. There was no automatic link to STORM. When creating a STORM incident the call handler did so manually. By July 2015 AVAYA was mainly used by the Divisional officers taking 101 calls, and PAD officers. Some core call handlers, having lost confidence in ASPIRE, preferred to use it.

The AVAYA After Call Button

[342] If the call handler's preference was to enter the details at the end of the call, it was necessary to press the 'After Call' button to prevent another call coming in until the current call was dealt with. The After Call button is a confusing name, if not a misnomer. For it to be effective it has to be utilised during the current call rather than at its conclusion, otherwise the call handler may be faced with another call immediately.

STORM

[343] STORM is Police Scotland's incident recording and database system for C3 Division. It has its own search facility. Searches can be made on, for example vehicle registration numbers, mobile numbers, addresses and earlier reported incidents. The search facility can be used without the need to create a STORM incident.

[344] STORM and ASPIRE communicated with each other. In the event that ASPIRE failed then the call handler reverted to AVAYA, manually inputted the incident details and manually transferred to STORM. If STORM failed then the whole system would be manual and incidents sent to the ACR by for example e-mail or in paper form

Call grading

[345] In July 2015 before forwarding a STORM incident to the ACR, the call handler assigned a priority to the incident graded as follows:

1. Immediate - An ongoing incident with an immediate or apparent threat to life or a serious crime in progress. The target dispatch time is 5 minutes. The

dispatch time is not the time that the resource is expected to arrive at the scene, but the time it is commanded to do so.

2. Priority – A crime or incident with a degree of urgency. The target dispatch time is 15 minutes.

3. Standard - Not an ongoing crime or incident but police attendance is required and failure to attend or delay may prejudice the outcome. The target dispatch time is 40 minutes.

4. Scheduled - A visit is arranged from the police within a 24-hour period.

5. Non-attendance - The matter is resolved by telephone.

[346] A STORM incident graded 1 and 2 was expected to be created and transferred to the ACR within 90 seconds. Once the STORM incident was received the controller could review the grading of the incident and move it either up or down. Any grade 1 call was immediately assessed by the controller.

Pot Books

[347] In July 2015 the use of what are known as Pot Books or scribble pads was widespread at Police Scotland. They were used by call handlers, Police Officers of all ranks, Supervisors and senior management. A Pot Book is a notebook used to take details of calls handled. These notes were generally made contemporaneously with the call, particularly by call handlers unable to talk and type at the same time. Pot Books varied in size from A4 to small notebooks. Call handlers got them from Police Scotland's stationary stock or bought them themselves from high street stationers.

[348] Although the tripartite system was designed to be operated without the need for Pot Books, call handlers at Bilston continued to use them. Often call handlers would be communicating with callers who were distressed, under the influence of drink or drugs, unsure of their location and often confused. Call handlers needed to make sense of these calls and to extract relevant information. Many call handlers used Pot Books to note information and then input only what they considered relevant information into the system. What was noted in the Pot Book was at the discretion of the call handler. Not all information in the Pot Book was necessarily included in a STORM incident and not all calls necessitated the creation of a STORM incident.

[349] The use of Pot Books was not prohibited. As at July 2015 there was no SOP, guidance documents or training to assist call handlers how to manage their Pot Books. There was no auditing of Pot Books. They were not signed in or out. There was no requirement for the user to account for their Pot Book. It was not subject to examination at the end of a shift. There was no system in place to ensure or cross check that calls had been recorded and dealt with appropriately. There was no requirement for the Pot Book to be retained at the Service Centre. It was not uncommon for call handlers to take them away with them at the conclusion of their shift. Brian Henry did so. The call handler was at liberty to destroy their Pot Book. Brian Henry destroyed the Pot Book he used after his shifts on 11th, 13th, 14th, 16th and 18 June 2015. His Pot Book for his shifts on 30th June 2015 and 4th and 5 July 2015 were retained, because he had not got round to destroying them.

[350] Ms McCall, KC challenges the Crown's submission that the use of Pot Books at Bilston was '*authorised*'. She submits that the practice is best described as '*tolerated*'. I reject both these descriptions. Firstly, it is clear from the evidence of Inspector Michaela Kerr and Laura Henderson that Pot Books were used not only in Bilston but at Glenrothes and all other Service Centres. Secondly, PIRC in its Interim Report describes the use of Pot Books as '*normal*'. Thirdly, in its Final Report, HMIC notes that the use of Pot Books was observed across all sites alongside ICTS systems. It acknowledged that Police Scotland encouraged call handlers to record information directly onto the CRM system but '*permits*' the use of Pot Books.

[351] The use of Pot Books was not '*authorised*' or '*permitted*' and it cannot be described as '*tolerated*'. It was a system of work and an accepted practice, helpful to the call handler in immediately noting details from a caller when necessary. They were essential tools in the event of a CRM failure. Some Service Centres, for example, Stirling and Glenrothes, did not have a CRM making their use essential. They continue to be used in a strictly regulated manner today.

[352] HMIC recommended that Police Scotland review the use of what it described as '*ad hoc*' Pot Books by call-handlers and provide definitive guidance on their use, issue and supervision. To that end from March 2016 Police Scotland instructed that all Pot Books must be formally issued by service managers, numbered, tracked and retained after use. From June 2018 the use of Pot Books across the C3 Division aligned to a national standard in terms of the type, referencing, distribution and storage.

[353] The use of Pot Books in Bilston in 2015 was a system of work. It was a defective system of work in that there was no requirement for the issuing, regulating or reconciling of Pot Books to ensure that entries had been actioned. That reconciliation could be as simple as scoring through entries once actioned or a check by a third party. If reconciliation was carried out diligently, an entry not acted upon would in all likelihood, be identified and remedied prior to the call handler's end of shift.

A reasonable precaution in relation to Pot Books

[354] A reasonable precaution would have been for Police Scotland to ensure that such a system of reconciliation was in place. If such a system had been in place, then at the end of Brian Henry's shift at 14.00 hours on 5 July 2015 he would have, in all probability, identified his failure to action the John Wilson Call 1. Had that happened and had it been actioned at that stage by the creation of a STORM incident the ACR would have deployed resources to the locus. Brian Henry assessed the call as a Grade 2 call. Given that grading, the blue Clio would probably have been found at some point that day resulting in the rescue and medical treatment of Lamara Bell. Treatment which if afforded in that time scale might realistically have resulted in the death of Lamara Bell being avoided.

28. Unidentified risks

[355] It was the expectation of Police Scotland that the tripartite system be used by call handlers throughout C3 Division and all call handlers trained in its use. It is reasonable

then to expect that the tripartite system itself would be subjected to a proper risk assessment. It was not. The risk that a call handler may fail to transfer details of a call onto STORM from AVAYA or for that matter ASPIRE was not assessed. That risk has to be broadened out and considered alongside the risk posed by the use of, unregulated, Pot Books.

[356] Such a risk assessment would have identified the process of taking a call, noting details and ultimately transferring an incident onto STORM. The final and crucial stage of call handling is the transfer of the STORM Incident to the ACR. An understanding of how that is done either manually or with the assistance of ASPIRE would have enabled mitigating measures to be put in place, particularly when Pot Books and AVAYA are used.

[357] The reasons for that risk not being identified are explained in considerable detail in the report prepared by Mr Sylvester-Evans, summarised as follows:

(i) Police Scotland never identified the risk in the first place, or if it did considered it negligible.

(ii) Police Scotland did not conduct a risk assessment as to how the call handling system might fail.

(iii) There was no formal Management of Change procedure for the C3IR Project which may have identified the risk as it evolved.

(iv) Police Scotland had no '*Near Miss*' or Notifiable Incident Procedure which captured incidents associated with call handling, allowing for lessons to be learned and remedial action to be taken.

[358] Historically, Laura Henderson was aware of two incidents which led to calls going unactioned. These incidents occurred in June 2010 and August 2012. Neither led to loss of life and both were dealt with on a disciplinary basis. Had these two incidents been captured and reviewed then the likelihood of the risk arising would have been identified.

[359] No assessment of the risk posed by the use of Pot Books was undertaken. The use of Pot Books within Police Scotland was widespread. They were used as a matter of course in Service Centres throughout C3 Division. There was no control over the use of Pot Books. There was no SOP governing their use. There was no system of reconciling or cross-checking to ensure that what was contained in the Pot Book had been actioned appropriately. That system of cross-checking could be as simple as scoring through entries in the Pot-Book or a supervisor's review of the Pot Book at the end of a shift.

[360] Mr Sylvester-Evans concludes that had a full risk assessment of the call handling system been carried out, while it is not certain that the specific risk that led to Brian Henry's lapse would have been identified it is *'more probable than not'* that it would.

[361] The failure of Police Scotland to properly risk assess the call handling procedures and have a system of reconciliation was an organisational failure. An organisational failure which led to the safety of the public being compromised and to the events of 5 July2015.

Was ASPIRE failsafe.

[362] At the time of the restructuring of C3 Division, there was an overconfidence on the part of Police Scotland that the ASPIRE system was '*failsafe*'. In 2015, used in the manner that it was intended meant that the risk of not transferring an incident was significantly reduced but it was not failsafe. It was open to manipulation.

[363] Due to its unreliability, call handlers at Bilston were not using ASPIRE operating instead the manual AVAYA and Pot Book system. When using ASPIRE, call handlers had identified a way to close it down without creating a STORM incident, a method known as 'tabbing through'.

[364] The risk that an incident was not transferred when a call handler operated ASPIRE was live but unlike the AVAYA and Pot Book system that failure depended on a conscious, deliberate decision on the part of the call handler rather than an innocent error.

29. The working environment at Bilston between January 2015 and July 2015.

[365] Assistant Chief Constable McCormick retired on 31st March 2015. His successor, Assistant Chief Constable Val Thomson assumed his role. Before moving on to what she discovered, it is useful to consider what it was like on the ground for those working in Bilston from January 2015 through to July 2015.

[366] Assistant Chief Constable Val Thomson was shocked by what she inherited in April 2015. She was not alone. The evidence of two witnesses, Laura Henderson and

Inspector Michaela Kerr is telling on the chaos that was abroad during the period from January 2015 through to April 2015, and beyond.

[367] Laura Henderson was appointed as Service Centre Manager on 1st January 2015, moving there in March 2015. Prior to her appointment she was the Glenrothes Service Centre Manager. On appointment she was responsible for 151 members of staff. She oversaw 12 Team Leaders. She reported to Amanda McDonald, the National Manager for Service Centres who in turn reported the Commander of C3 Division.

[368] Laura Henderson, described Bilston as being in a state of disarray and under developed when she took up her post. She identified issues with all aspects of the operation including performance, resources, processes and recruitment. The main cause of the disarray was the lack of staff, but other factors contributed to and caused problems with staff morale. She felt she was '*firefighting*' and '*plate spinning*' on a daily basis. She did not think that the problems facing Bilston could be resolved quickly. That turned out to be a shrewd assessment. The main issues she identified, other than the lack of staff, can be summarised as follows:

(i) ASPIRE was new to the core call handlers, having been introduced to Bilston in October/November 2014. It was the CRM used in the West. Prior to restructuring the CRM in the East was VANTAGE. Team Leaders and call handlers were struggling to get to grips with ASPIRE.

(ii) ASPIRE was proving seriously unreliable. It often failed or froze during a call. When that happened call handlers had to re-start the input to STORM. Not all failures were reported via the Police Scotland ICT portal, otherwise the portal

would be '*bombarded*' on a daily basis. Mr Sylvester-Evans calculated that during the period 1st April 2015 to 5 July 2015 on 65% of all days a problem was experienced with the use of ASPIRE or STORM.

(iii) Laura Henderson kept a spreadsheet of problems that arose in the Service Centre. It contained over 300 reported issues. Not all related to problems with ASPIRE.

(iv) There were delays in answering both 101 and 999 calls. Calls were often dropped, as a result of IT failure.

(v) Some core staff preferred to use AVAYA. Inspector Michaela Kerr estimated that at one point around 60 - 70% of trained staff bypassed ASPIRE by 'tabbing through' the pre-populated ASPIRE screens directly to STORM.

(vi) Call handlers had difficulty dealing with calls from other areas as the A-Z guidance on ASPIRE was legacy Strathclyde guidance. Bilston staff found it unhelpful if not a hindrance. It had not been updated with guidance for the East.

(vii) Officers in PAD, using AVAYA, felt pressured into handling calls when the Service Centre was busy and felt insufficiently trained to do so.

(viii) There was a distinct difference in the way that East and West call handlers dealt with calls. In the West the practice was to put limited information onto STORM before transferring to the ACR. The practice in the East was to input significantly more information and at times seek to resolve matters at first instance rather than create a STORM incident. As a result the East call handling

time was longer than the West. Call handlers felt harassed into shortening the length of calls.

(ix) Legacy staff who transferred to Bilston retained their terms and conditions when job matched. New staff were employed on different and more beneficial contracts. This caused resentment. It took until early 2019 to harmonise the pay scales.

(x) Staff felt poorly informed, unsupported and overworked. Some felt that they had been lied to by senior management. The mood in the Service Centre was fractious, and staff made their feelings known to their Team Leaders. That tension, at times, boiled over into verbal confrontations.

(xi) Team Leaders felt overwhelmed with the responsibility of managing their team in such difficult circumstances.

(xii) The working conditions at Bilston led to an increase in sick leave taken by staff. As at 1st June 2015 from a staff of 325 there were 25 absences, 12 were classed as long term, 8 were stress related illness of which 6 were work related.

(xiii) The union Unison complained that management did not understand what good performance was. As late as 7 July 2015, Mr Taylor from Unison said at a Gold Group meeting that he considered staff morale and performance at Bilston to be '*Worse than two years ago*' and that when staff from the West attended Bilston they could not believe the quantity and amount of work the Service Centre was having to deal with.

[369] Very quickly after taking up her post Laura Henderson felt overwhelmed by the volume of work with which she was dealing. She requested an additional layer of management between her and the Team Leaders. She described her work as insurmountable and that the Service Centre was becoming overwhelmed. Her request was granted and Diane Livingstone and Anne Hardie were appointed on a temporary basis as Duty Managers. Chief Inspector Gordon McCreadie seconded Inspector Michaela Kerr to assist Laura Henderson.

[370] Ms McCall, KC makes some submissions on this matter that I do not accept. Firstly in relation to the non-use of ASPIRE by core call handlers, she suggests that this was *ad hoc* and downplays the level of non-use by core call handlers. The evidence from the Bilston floor was that the non-use of ASPIRE was a regular occurrence from the time it went live until July 2015. It was only following an internal investigation into the John Wilson Call 1 that, on 9th July 2015, an order was given to Team Leaders to ensure that all call handlers used ASPIRE at all times and with immediate effect. The practice of 'tabbing through' was ordered to stop. Secondly she challenges the Crown's description of ASPIRE as displaying reliability issues, and offers Mark Hargreaves' evidence that the system had been tested under pressure from multiple users and no performance issues had been identified. It had not been rigorously tested at Bilston. Ms McCall's submission is not supported by the evidence of those working at Bilston or the statistical data produced by Mr Sylvester-Evans, who ultimately described ASPIRE at Bilston as '*not fit for purpose*'.

[371] I do accept her submission that the roll out of the West ASPIRE CRM at Bilston was an interim measure and deemed reasonable by HMICS. I also accept and find that the decision not to train Divisional officers in the use of ASPIRE was made without the knowledge or approval of ACC Thomson, CS Speirs and the C3IR Project Board.

30. Assistant Chief Constable Val Thomson's return to Bilston

[372] ACC Val Thomson was involved with the C3IR Project from the outset. She was Chief Superintendent, Divisional Commander for C3 Division from April 2013 until taking over as ACC from ACC McCormick on 6th April 2015. From 31st December 2014, until taking up her promoted post she attended the National College of Policing and undertook the Strategic Command Course. She was not involved in the C3IR Project over that period but was kept informed as to developments there by staff. She was told that, following the transfer of work from Stirling, performance levels had dropped significantly and staff morale was very low. She brought this to the attention of ACC McCormick. He told her he was aware of the situation and would deal with it.

[373] In September 2014, ACC Thomson was confident Bilston would cope with the increased workload on the closure of Stirling. She was not so confident that it would do so on the closure of Glenrothes. In November 2014, she made the SPA aware of an anticipated shortfall in staff. Her view was that after the closure of Stirling a further assessment of the needs of Bilston should be made.

[374] ACC Thomson took over from ACC McCormick in April 2015, and was assured by him that all was well at Bilston. There were ongoing recruitment issues but they were being addressed and performance levels were good.

[375] ACC Thomson chaired the meeting of the Project Board for the first time on her return to Bilston on 8 April 2015. Prior to that meeting the risk register was circulated to all members. She noted that the register scored Risk 6 at 20 - Very High and the following comment; '… *unless efficient improvements are made in advance of planned staffing reductions, insufficient resources will be available within retained facilities to meet transferred demand.'* That caused her serious concern, if not alarm. She said she that she was '*surprised at what she had uncovered*'. I took careful note of these words. They were not used lightly. Throughout her evidence she was careful in her language and particularly so on this matter. The picture of Bilston presented by ACC McCormick was inaccurate and a misrepresentation. I take from her evidence that not only was the picture inaccurate but that he had hidden the true picture from her.

[376] Chief Superintendent Alan Speirs took up his post as C3 Divisional Commander on 13th April 2015. He was instructed by ACC Thomson to review staffing levels, performance and whether or not the Risk 6 score of 20 was accurate. The risk register was taken '*off table*' to be reviewed and ensure it was fit for purpose.

[377] On 22nd April 2015 CS Speirs reported that the primary cause of the poor handling at Bilston was a shortage of staff and that there was no on-going recruitment to resolve the issue. The last recruitment campaign concluded in January/February 2015 and was largely unsuccessful attracting only 22 applications.

[378] CS Speirs assessed the situation as '*critical*', and that he may have to declare a critical incident. A critical incident, in the context of Bilston, is a situation where the effectiveness of the police response is likely to have a detrimental impact on the service it can provide and protect the communities it serves. It was clear to CS Speirs that immediate action was needed to address the situation.

[379] Following CS Speirs' report ACC Thomson requested, and was granted, a meeting with Sir Stephen House, the then Chief Constable. She did not think that the situation could be resolved at Divisional level. After briefing him he pledged his full support in the allocation of resources to recover the situation. He considered resolution of the issue to be Police Scotland's number one priority. The SLB met that day chaired by the Chief Constable and was accurately briefed by ACC Thomson on the state of Bilston.

[380] On 23rd April 2015, CS Speirs prepared a Briefing Paper entitled '*Action Plan to tackle Contact, Command and Control Division Service Centre Resourcing Issues'* for the Chief Constable and Michael Mathieson the then Scottish Government Justice Secretary. The paper outlined the difficulties across C3 Division and proposed solutions. He gave the chair of the SPA with a verbal briefing on the challenges the C3IR Project faced.

[381] In response to the crisis CS Speirs established and chaired a Gold Group. The Gold Group comprised senior police officers, civilian managers, HR personnel, trainers, ICT personnel, Corporate Communications and Union representatives.

[382] On 24th April 2015 the Gold Group met to formulate and co-ordinate the response to performance and staffing levels at Bilston. That decision was intimated to the Project Board at its meeting on 1st May 2015.

[383] Before considering what action was proposed at the Gold Group meeting of 24th April the following should be noted:

(i) On 24th April 2015, ACC Thomson and CS Speirs met with the Chair and Chief Executive of the SPA in Edinburgh and gave them the same briefing the Chief Constable received. They offered their full support.

(ii) On 29th April 2015, she gave the same briefing to the full board of the SPA. The Chief Constable was present. She was challenged as to why the SPA had not been made aware of the issues until they reached a critical stage. The Chief Constable intervened, confirming that he personally would be looking into that matter.

(iii) On 5 May 2015, ACC Thomson attended the Scottish Parliament with CS Speirs and Deputy Chief Constable Rose Fitzpatrick to meet and brief the Justice Secretary. He expressed concern that the situation had reached a critical stage before he was advised. He requested and was afforded weekly performance updates in relation to call handling at Bilston.

(iv) The C3 Gold Group met on Friday 8 May 2015 and established the C3 Service Centre Process Development Group ('PDG'). The remit of the group was, amongst other things, to coordinate the improvement of Bilston. The group reported to the C3 Gold Group.

(v) On 15 May 2015 a Strategic Priority Group met to scope the scale of the issues affecting Bilston and to prioritise them for resolution.

(vi) On 16th May 2015 Supt David Tonks prepared a paper on the work of the PDG and a draft development road map was prepared.

C3 Gold Group Action plan

[384] The meeting of the Gold Group on 24th April 2015 was the first of a series of meetings designed to deal with recruitment at Bilston. It was decided at this meeting that non-core Divisional officers from out with C3 Division, could be used as an interim measure until such time as a full complement of core staff was achieved.

[385] At the meeting on 24th April 2015, Chief Inspector Andrew McDowall, then head of the C3 Division Coordination Unit, was tasked with identifying suitably skilled officers available to assist.

[386] At the conclusion of the meeting on 24th April 2015, CI McDowall met with Inspector John Galbraith and others including Simon Jones. Mr Jones was the interim Training Business Partner at Police Scotland and responsible for training at C3 Division. The meeting was held to formulate a plan to recruit Divisional officers. In February 2015, faced with the threat of industrial action at Service Centres, Simon Jones identified suitably trained Divisional officers who could be seconded. He identified approximately 150 officers in the East and West areas of Police Scotland. CI McDowall e-mailed these officers in the following terms:

> "You have been identified from a SCOPE skills search as potentially having policing experience and skills in the STORM command and control system.
>
> An opportunity currently exists on a voluntary overtime basis to provide support to the Force Contact Centres in the West and East Command areas (Govan, Motherwell and Bilston Glen service centres). This overtime will not impinge upon your current duties and would be allocated with due regard to your own individual working time hours and well-being.
>
> The role that you would undertake would be dependent upon the nature of your experience and skills and training would be provided to equip you to undertake the following roles:
>
> - Non-Emergency call taking
> - Public Assistance Desk
> - 'Contact Us', E-mail administration
>
> Should this opportunity be of interest and you are confident using STORM Unity then please reply by email to **C3 Division DCU** prior to Friday 01 may 2015. Many thanks"

[387] It is not clear from the terms of that email, but CI McDowall expected Divisional officers to be trained to '*Call Taker*' level. That is officers who had undertaken training on STORM and competent in incident creation. It is not clear from that email what training was to be provided. CI McDowall considered that he did not have time to make any formal training request in relation to non-core staff. A training package involved a full training needs analysis and the scoping of resources, equipment and accommodation. As he put it the ongoing risk to the public was that; *'Bilston did not have the capacity to answer the phone day after day'*, and that exercise simply delayed resolution of a critical situation.

[388] CI McDowall's e-mail was followed by an e-mail from CS Speirs to all Divisional Commanders in the East and West supporting the recruitment campaign and encouraging them to assist. CI McDowall's email initially produced an encouraging

response. By 30th April 2015, 25 Divisional officers had volunteered for overtime. How many of those were in relation to Bilston as opposed to the West is unclear.

[389] Over the period 27 April 2015 to 19th May 2015, there was a concerted effort to identify suitable volunteers for Bilston. However as at 19th May 2015, there was but five. By 4th June 2015 the five volunteers were ready to start at Bilston and AVAYA log-ins had been arranged for them. It is of note that they were provided with log ins to AVAYA rather than ASPIRE.

[390] As at 5 June 2015, despite efforts to attract Divisional officers to Bilston, it was still understaffed. Some officers who volunteered were found not to have the necessary experience. On that date, in an effort to bolster the number of Divisional officers at Bilston, Inspector Michaela Kerr sent an email to '*all Sergeants*'. That email and the response to it is considered below.

[391] While recruitment was an ongoing problem, by June 2015 the effort put into assisting Bilston was producing better performance figures. As at 9th June 2015, Bilston averaged 94% for 101 calls and 93% for 999 calls. The West's figures were 95% in each.

31. Inspector Michaela Kerr's decision to train Divisional Officers in the use of AVAYA only.

[392] Inspector Michaela Kerr took the decision to have the Divisional officers trained in the use of AVAYA when handling 101 calls at Bilston. Before looking at why she made that decision, consideration must be given as to how she came to be at Bilston, what roles she was instructed to perform and her qualifications to do so. Her evidence

underscores the confusion in the minds of management and senior officers on the distinction between AVAYA and ASPIRE. That confusion led to the opportunity for senior officers to countermand her decision being missed.

[393] Michaela Kerr was an honest, credible and other than in one or two minor matters a reliable witness. She accepted responsibility for her decision and was able to justify it. Her decision, made following an order received from a senior officer, was based on good reason and in an effort to support beleaguered colleagues at Bilston.

[394] Michaela Kerr joined Lothian and Borders police in 1989. In January 2014, she transferred to C3 Division at Bilston. She completed a Tactical Firearms course in March of that year. In January 2015, she was deployed as a Relief Inspector in the ACR at Bilston. Her primary function was to monitor and oversee developing incidents until the appropriate resources were deployed.

[395] In her police career she never worked as an emergency call-handler. She had very little experience of call handling in general. She was last trained at a call-taker's course in 2007. She was confident in her use of STORM. As a member of the legacy Lothian and Borders force she operated VANTAGE CRM. She received little training on AVAYA/ASPIRE but had a general understanding of it. She understood that AVAYA and ASPIRE were not one and the same thing. I accept that, ultimately, she did understand the difference but, as with other senior officers, it took a while for that to be clear in her mind. Initially she confused the two systems and thought that they were one and the same thing, with interchangeable names. That she became aware of the distinction between the systems is confirmed in an email she sent to Team Leaders at

Bilston on 11th June 2015 confirming that AVAYA will be used by the Divisional officers unless trained in the use of ASPIRE.

[396] On 19th April 2015, Inspector Michaela Kerr was seconded to support Laura Henderson. A senior police officer was told to support the civilian Service Centre manager. Her brief was to identify the reasons for the poor call handling performance at Bilston. That brief was expanded by Laura Henderson, who appointed her as her administrative assistant. Her secondment, anticipated to last no more than three weeks, continued until 19th June 2015. By her own admission Michaela Kerr felt under qualified for the role. She had no experience of managing a Service Centre.

[397] Michaela Kerr very quickly felt as overwhelmed as Laura Henderson and for all the same reasons. She recognised that the Service Centre was experiencing significant problems and low staff morale. Before realising the existence of the spreadsheet created by Laura Henderson, she had created her own. Her list mirrored Laura Henderson's spreadsheet. It was clear that staff shortage was the main problem.

[398] Michaela Kerr was told, in June 2015, by CI Stuart Simpson that she needed to '*Get people in*' to Bilston and as soon as possible. He had been pressed in turn by CS Speirs. This was at a time when Diane Livingstone, Donna Kennedy and Laura Henderson were absent and against a background of being told by Laura Henderson not to get involved in personnel matters. She was uncomfortable with this task. She considered it a role for HR and the civilian managers.

[399] In an effort to get people in, at 09.32 hours on 5 June 2015, she emailed 'all Sergeants' at Police Scotland offering overtime at Bilston taking calls from the public.

The qualification for the role was to be trained to 'Call Taker' level on STORM. When that training took place was irrelevant provided the applicant was competent in creating and transferring incidents onto "Scope". For "Scope" should be read STORM. The email stipulated that applicants would require to attend Bilston to be trained on AVAYA prior to working in the Service Centre. It could not be clearer then that the training offered is on AVAYA, not ASPIRE.

[400] Inspector Kerr copied her e-mail to Inspector Galbraith and CI McDowall. CI McDowall was the CI for Service Delivery within C3 Division and responsible for Training and Planning. CI McDowall was Inspector Galbraith's line manager. Inspector Kerr sent the e-mail to ensure that her senior officers were aware of her decision and to offer them the opportunity to review or countermand it. She was looking for confirmation that her decision was good. At no stage did either officer demur. At 10.21 hours, same date, she emailed both officers telling them that she had a very good response from people '*Trained to call taker level.*' and able to create STORM incidents. The email informed them that she asked Dev Mukherjee, System Administration Manager, to allocate the applicants AVAYA numbers once trained. Once again, it should be noted that her request was for AVAYA numbers rather than ASPIRE.

[401] If, initially, there was confusion in the mind of Michaela Kerr as to the distinction between AVAYA and ASPIRE, she was not alone. In June 2015 Inspector Galbraith thought that AVAYA and ASPIRE were one and the same thing.

[402] Until July 2015, CI McDowall was unaware that AVAYA was a separate system from ASPIRE. In his statement to PIRC in February 2016, CI McDowall was unable to

confirm which senior officers understood the distinction between the systems in July 2015. In his view senior officers did not need to know the difference. They had local managers dealing with the day to day business. He maintained that whatever the name, he expected all call handlers, core or non-core to be trained in the tripartite system.

[403] It was that level of misunderstanding that led to those who had the opportunity to review or countermand Michaela Kerr's decision missing it. A better understanding by senior officers and senior managers as to the distinction between AVAYA and ASPIRE would have helped the hierarchy understand the implications of her decision. Had a risk assessment of the call handling system been undertaken then an appreciation of the risk it created may have been apparent. That understanding would have afforded them the opportunity to countermand her decision.

[404] There was a degree of conflict in the evidence of Laura Henderson and Michaela Kerr as to whether or not they had a conversation, prior to the discovery of the blue Clio, about what system was being operated by Divisional officers. I prefer the evidence of Michaela Kerr. I am satisfied that there was such a discussion. I am satisfied that Michaela Kerr told Laura Henderson of her decision to train the Divisional officers in AVAYA and her reasons for doing so. Laura Henderson knew prior to 5 July 2015 that Brian Henry was not using ASPIRE while working at Bilston.

Inspector Michaela Kerr's reasoning

[405] Michaela Kerr took the decision to have the Divisional officers operate AVAYA as there was a desperate need for assistance at Bilston, and for the following further reasons:

(i) The PAD officers were using AVAYA.

(ii) Divisional officers would not handle 999 calls.

(iii) ASPIRE was proving unreliable and many call handlers were avoiding using it and operating AVAYA.

(iv) The use of Divisional officers was a stop gap until the complement of full time staff was achieved, trained and operational.

(v) The use of AVAYA, with or without Pot Books was a simpler system to use and train the Divisional officers on.

(vi) There was less risk that the Divisional officers would '*Muck up*' if using the simpler and more reliable AVAYA. That afforded the Divisional officers a degree of protection.

Assessment of Inspector Michaela Kerr's decision

[406] The Crown invites the Inquiry to consider the decision of Michaela Kerr not to train the Divisional officers in the use of ASPIRE but to attach no criticism or make any findings in respect of her as an individual. That invitation is repeated in the submissions made on her behalf by her Counsel. I accept these submissions and conclude that given what she was confronted with, the pressure she was put under to

get people into Bilston and in the absence of Laura Henderson, Diane Livingston and Donna Kennedy her decision was understandable. Her justification for making the decision is sound. The statistics prove that her decision was helpful to the performance of Bilston. The Divisional officers, including Brian Henry, worked many shifts dealing with many calls of a varying nature and all, other than the John Wilson Call 1, were dealt with professionally and without incident. The Divisional officers should have had better, formalised training. That training should have been in the use of ASPIRE. That it was not is not solely the fault of Michaela Kerr.

[407] Inspector Kerr took action and made her decision with a sense of urgency. A sense of urgency lost by the Project Board and ACC McCormick between January and April 2015. Since April 2015, despite Gold Group, Service Centre Process Development Group, Strategic Priority Group, SPA and SLB meetings together with interest from the Justice Minister it was largely her decision that got bodies in to mitigate the problems facing Bilston. Until her intervention recruitment of temporary staff was negligible. She, like Brian Henry was failed by Police Scotland. In her submissions, her Counsel refers to Michaela Kerr working against a background of '*organisational failure*'. From all of the evidence that is a proper conclusion.

[408] The decision taken by Michaela Kerr was contrary to Police Scotland's expectation that all call handlers should be trained in and operate the tripartite system, throughout C3 Division. It was a decision which departed from Police Scotland's planned system of work.

32. Training of Divisional officers;

[409] The confusion as to what system the Divisional officers should use permeated into what training they should be given and who should deliver it.

[410] When the use of Divisional officers at Bilston was mooted at the Gold Group meeting on 24th April 2015, their training needs were considered. On 5 May 2015, CI McDowall wanted a training and a '*Welcome to C3*' pack for the Divisional officers. On 12th May 2015 Inspector Galbraith emailed Laura Henderson and Michaela Kerr explaining that in the West volunteers were invited in for three hours for a CRM update and the opportunity to shadow a core call-handler. This was the training to be adopted by Bilston. However, in an email from Inspector Galbraith to Michaela Kerr on 5 June 2015 he states; '*The position at present is that we have trawled SCOPE for all staff trained in STORM to at least call taker for the last 4 years and contacted them to ascertain their willingness to assist. If they respond we bring them in for 3 hours to train them in the AVAYA phone system and to let them sit with a 'buddy' for a couple of hours. They can the volunteer for OT'*. Again, AVAYA is referred to rather than ASPIRE.

[411] Laura Henderson is vague as to what system the Divisional officers were to be trained in and then use. In her oral evidence she thought that AVAYA was a CRM. She thought that training was to be on ASPIRE but was not certain where that understanding came from. She had no concerns that the Divisional officers were not using ASPIRE, because she came from a legacy force that did not operate a CRM, the PAD officers were not using it and ASPIRE was proving inefficient.

[412] On 8 June 2015, Michaela Kerr emailed Bilston supervisors to let them know that a number of Divisional officers would be attending for initial training on AVAYA and they should be provided with log-ins. She followed that up by email dated 11th June 2015 confirming that Divisional officers should; *'…sit down with a service adviser for a short time to watch the calls being created, then be shown how to log onto the phones. Once they log on they can take calls whilst supported by nearby SA and stay for 1-2 hours or until they feel comfortable and know what they are doing'.*

[413] The confusion as to the system to be operated and training is underscored by the evidence of Lindsey Hammond, the Training Sergeant at Bilston. Despite her rank and role she was never asked to train the Divisional officers. She warned Laura Henderson that the planned training was inadequate and that it posed a risk to the Service Centre. That risk was acknowledged by Laura Henderson.

[414] So far as Lindsey Hammond was concerned, training should have been over at least a day and a half followed by a number of days shadowing an experienced call handler. How Lindsey Hammond felt about the situation is summed up in her email to Simon Jones on 16th July 2015; *'…..in response to your email I just wanted to clarify that I was not involved in training any of the officers brought in…. The whole thing was done without consulting Linda and I, and we were not asked to provide any training for them at any point. When Linda and I found out about it, we both agreed that it was not ideal. I had a meeting with Laura on 15 June, after my return from the SPC and after her return from annual leave, as I wanted to catch up with the changes she'd been making in the SC. At that time I asked her what training these additional officers were getting, and she explained briefly that they were getting 3*

or 4 hours during which they would be shown how to use AVAYA/ASPIRE and shadow another call taker and that they were taking care of it all on the floor of the SC without involving Linda or I (presumably they had decided this because Linda and I were largely committed at the time to training new recruits). I told her this was a risk, and she acknowledged that it was'.

[415] The communication between senior officers and trainers as to what training was to be provided and by whom is woeful. In a statement given to PIRC on 5 August 2015, CI McDowall stated that Simon Jones, devised a training program for the Divisional officers. He said the program was documented and included:

(i) CRM/ASPIRE training.

(ii) A STORM refresher, and

(iii) Shadowing experienced call takers and mentoring by experienced call takers.

He informed the PIRC investigators that Michaela Kerr and Laura Henderson were responsible for co-ordinating the program. In a subsequent statement to PIRC, dated 1st September 2015, he accepted there was no documentation to support his understanding but that he recalled a conversation with Simon Jones in which he expressed the need for a training package.

[416] Simon Jones' evidence is that that he was never asked to frame a training package let alone the one outlined by CI McDowall. His understanding was that the Service Centre managers were responsible for the training.

[417] In May 2015, Diane Livingston was a temporary Duty Manager at Bilston. She had 20 years' experience in the call centre industry. She had been employed by

Strathclyde Police and then Police Scotland for 11 years. Prior to ASPIRE going live, in October 2014, she was seconded to Bilston to conduct '*User Acceptance*' testing. In April 2015, when the issues at Bilston became obvious to ACC Thomson and CS Speirs she was invited back to train the Team Leaders on the AVAYA and ASPIRE systems. She found the core call handlers to be nervous of ASPIRE and concerned at its failings. She had no input into the training of the Divisional officers.

[418] Laura Henderson thought Michaela Kerr was tasked with co-ordinating training.

[419] On arrival at Bilston in 2015, Laura Henderson was concerned about training in general. Training at that time was undertaken by legacy Lothian and Borders Police Trainers including Lindsey Hammond and the Team Leaders. She said call handlers complained of a lack of consistency in training. She instructed Donna Kennedy, to review the current procedures with a view to creating a revised training programme. Her evidence as to who was instructed to train the Divisional officers is vague. Her understanding of what system they were to be trained on is vague. She is clear that she considered the Team Leaders and experienced call handlers better able to provide training than the L&B Trainers.

33. Practical effect of the training confusion

[420] The confusion as to what training was to be offered, in what and by whom is apparent in the experiences of a number of Divisional officers when they attended Bilston in response to either CI McDowall or Inspector Kerr's emails. That confusion spilled over, in practical terms, to the training that was actually provided. The training

offered to Brian Henry will be considered next but in the meantime a useful exercise, illuminating the confusion abroad, is to consider the training of other Divisional officers;

1. In April 2015, David Selfridge was a retired police officer with 31 years' experience. He was employed at Leith Police station as a Public Enquiry Support Assistant. He created STORM incidents and transferred them to the ACR. In 2014, he was trained in STORM call taking. The course lasted three days. He responded to CI McDowall's email and arrangements were made for him to attend Bilston on 19th May 2015 for training. On arrival, he formed the impression that he was not expected. He was taken to a call handler and sat with him while he took calls. He had no head set to listen in on until he managed to find one himself. He was shown how to populate the ASPIRE screen and transfer it to the ACR. After an hour he was transferred to another call handler and took alternative calls using ASPIRE. The call handler was questioned by a supervisor on the length of time his calls were taking. The call handler explained he was training Mr Selfridge. The supervisor was unaware of this arrangement. During the training session ASPIRE froze on two occasions and took around 10 minutes to reboot. Mr Selfridge's shift lasted three hours at the end of which he was told by a supervisor that he would be contacted when needed. He heard nothing further from Bilston until he made contact asking for an update. For various, good, reasons Mr Selfridge did not work another shift at Bilston. On the one shift there he used a Pot Book.

2. PC Susan Pearson responded to the email from CI McDowall and on 29th April 2015, volunteered to assist at Bilston. At that date she had 13 years police service. She worked in the Crime Management office in Dalkeith police station and was a trained STORM call taker. She attended Bilston on 26th May 2015. It was made clear to her that she would be operating AVAYA. Her training consisted of shadowing a call handler operating ASPIRE. After two hours she was provided with an AVAYA log-in and an A4 sheet of paper containing operating details. During the last half hour of her shift she received three calls in quick succession as she did not understand how the 'After Call Work' button worked. She returned to Bilston on 17 June 2015 and operated AVAYA. She had two Pot Books. One she used in her day job at Dalkeith, the other at Bilston. She obtained them from the Police stationary cupboard.

3. Sergeant Darren Cook was trained in STORM call taking in 2010. He attended Bilston on 14th June 2015 and ASPIRE was explained to him. He shadowed a call handler using the system. At the conclusion of this session he was confident in his ability to operate ASPIRE. He returned on 15 June 2015 and was instructed to take 999 rather than 101 calls. He refused as he was not confident that he could do so. He was given a ten minute input on AVAYA and took calls. He used a Pot Book obtained from the Police stationery cupboard.

4. Constable Ian Nicolson was a member the Major Investigations Team at Livingston. He was trained as a STORM call taker in 2008. He attended Bilston on 9th June 2015. It was made clear to him that he would be taking 101 calls and

operating AVAYA. He received three hours training, shadowing two call handlers, both operating ASPIRE. The system's functions and capabilities were explained to him. On Saturday 20th June 2015, he attended Bilston and was handed an A4 sheet of paper with AVAYA log-in details and basic instructions on its use and left to take calls. Throughout his time at Bilston he used a Pot Book. On 8 August 2015 he was trained, over a period of two hours, in the use of ASPIRE. He used a Pot Book when operating the ASPIRE.

5. Sergeant John Kerr attended Bilston for training on 10th June 2015. He was a police officer with 21 years' service, last trained in STORM in 2009. His Bilston training consisted of shadowing a call handler operating ASPIRE. He operated ASPIRE under the call handler's log in details. He returned on 15 June 2015 to be told to operate AVAYA. He was given a given a 10 minute input on AVAYA and left to take calls. He learned through experience when to use the After Call Button. When he attended on 12th July 2015, he was sent home as he had not been trained in ASPIRE. On 14th July 2015 he was given a four hour training session on ASPIRE. He used a Pot Book to assist him when operation either AVAYA or ASPIRE.

6. Constable Simon Wilkinson attended Bilston and was given a 15 minute instruction on AVAYA. He was assigned to an experienced call handler to listen in before taking calls himself. He had issues with work practices at Bilston and felt he had time restraints placed on him when dealing with calls. He felt

compromised in his ability to deal with callers' needs. He used a Pot Book to assist him.

7. Constable Susan Hogg attended Bilston on 17 June 2015 and was assigned to an experienced call handler using ASPIRE. She was aware of the distinction between ASPIRE and AVAYA. She was given instruction on the use of AVAYA and for the last hour of her shift used it to answer calls. She attended for a shift on 11th July 2015 and was trained in the use of ASPIRE. That training consisted of listening to an experienced call handler for approximately two hours and shown the system's functions. On any shift she worked post 5 July 2015 she operated ASPIRE. She used a Pot Book throughout her time at Bilston.

8. Constable Alan Curran attended Bilston for training on 11th June 2015. He was assigned to an experienced call handler using ASPIRE for approximately one hour before being shown how to use AVAYA. For the next hour he answered calls on AVAYA. His request that day, repeated on 18 June 2015, to be trained on ASPIRE was refused. Constable Curran did not use a Pot Book. He was confident in his ability to converse with a caller and type simultaneously.

34. Brian Henry

[421] It was into this confused, fractious working environment that that Brian Henry volunteered to assist.

[422] Brian Henry gave evidence to the inquiry and did not shrink from the fact that he took the John Wilson Call 1 on 5 July 2015, and failed to action it. Mr Henry wanted to

give evidence to the Inquiry. He understands that it is important that his actions are examined and the consequences of his failure acknowledged. He has cooperated with every agency investigating this matter when requested to do so. He has given PIRC three statements dated 26th October 2015, 19th January 2016 and 4th January 2018. He provided the Inquiry with a 52 page statement prior to giving evidence.

[423] At the very start of his evidence Mr Henry acknowledged that the families of John Yuill and Lamara Bell had been caused loss and grief as a result of his inaction. He wanted them to know how very sorry he was for their loss. He addressed those family members in court directly. It was a genuine and heartfelt apology from a man who said he has been tortured over the years since the accident trying to work out what happened and to provide an explanation for them. Ultimately he is unable to do that, beyond simple human error.

[424] Brian Henry retired from Police Scotland as a Sergeant on 31st August 2018, after 30 years' service. Prior to retirement he was a deputy Crime Manager based at Dalkeith working Monday to Friday between the hours of 07.00 - 15.00 hours.

[425] Before joining the police force Brian Henry was a farmer. A matter that is important in his recollection of the John Wilson Call 1. In 1992 he passed his Sergeant's exams and in 2006 was promoted to Sergeant. On promotion he took up a post in the Response Team at Galashiels Police Station. After three years with that team he took up the role of Custody Sergeant in Dalkeith. In 2011, he was the Intelligence Sergeant there. On formation of Police Scotland Mr Henry became a Crime Manager at Dalkeith and remained in that position until he retired.

[426] Historically, each Division of the legacy force had its own Divisional Control Room. Mr Henry worked in legacy E Division based at Dalkeith. Between 1997 and 2000 Mr Henry was a relief Constable covering periods of leave in the Divisional Control Room, handling 999 calls. When working as a relief officer, he used the then Command and Control system and dispatched resources by radio. The Control Room is akin to a switchboard, with queuing calls graded for answer. Pot Books were used by both Police and Civilian staff. If resources were dispatched that was recorded on the system. Calls dealt with on the basis of '*Advice given*' or '*No call out required*' were not recorded. The call taker was responsible for creating an incident report and putting the details on to the Command and Control system. What training he had consisted of informal shadowing of a more experienced colleague before being sanctioned to work alone.

[427] In November 2007, Brian Henry attended a two day course on STORM at Bilston. He describes it as a supervisor's course, providing him with an understanding of STORM in his role as an operational Response Team Sergeant. It was a course designed to enable a Sergeant to manage his team and ensure that calls were dealt with appropriately. As a result of that training, and his police experience, Brian Henry knew how to use STORM. He was not trained as a call-handler.

[428] Brian Henry's Police Scotland Training Records disclose the following courses undertaken by him:

(i) In November 1990 he attended a five day course entitled '*Captor Advanced*', on the Command and Control system.

(ii) In June 1997, a one day course on the Command and Control System.

(iii) On 5 November 2007, a one day course on STORM.

(iv) On 12th November 2007, a two day STORM Call Taker course. This course was designed to train officers on the awareness of incoming calls and how to record them.

[429] Distilling Mr Henry's evidence, it comes to this. Prior to starting overtime at Bilston in 2015 he had little or no experience as a call handler. He was competent in the use of STORM. He assessed his competence as good but slower than those who regularly used it.

[430] On receipt of Inspector Kerr's e-mail Brian Henry volunteered. He was confident that he could find his way around STORM. Mr Henry added an important caveat, he told Inspector Kerr, he had been trained '*Many moons ago.*' and that he would need a refresher.

[431] Mr Henry did not know how AVAYA and ASPIRE operated. As a member of the legacy Lothian and Borders force he operated VANTAGE.

[432] Mr Henry's offer to assist was not motivated by money. He was a Police Sergeant. His wife was a Sergeant working in the ACR at Bilston. He had no financial worries. He was not overworked or fatigued. He was not under stress. He had no underlying illness. There was nothing impacting on him which would distract him from doing his job either at Dalkeith or Bilston. He was aware that Bilston was under significant pressure. He was aware that those working in Bilston were under stress and not coping well. It was against that background that he offered his services.

[433] Mr Henry attended Bilston on Thursday 11th June 2015 at 16.00 hours and sat with an experienced call handler to 'shadow' her. He did this for two hours while she dealt with calls on ASPIRE. She explained that he would not be using ASPIRE.

[434] He is vague in his recollection of how he was trained in the use of AVAYA. That vagueness arises out of the passage of time. He accepts that to some degree he was trained and after a coffee break he was taking 101 calls. To quote him he was, after a couple of hours, '*Flying solo*'.

[435] Prior to taking calls, he was not provided with documentation to assist his understanding of AVAYA. He was not trained how to handle calls. He relied on his policing experience to draw relevant information from the caller. He was not instructed to record details of calls for which he did not create a STORM incident. He understood that he had four options when dealing with a call; give advice; create a STORM incident; transfer the call to the ACR or send an e-mail to another police officer.

[436] An analysis of the eight shifts Mr Henry worked at Bilston demonstrates that he was competent in taking calls and creating STORM incidents. He was considered an enthusiastic and diligent colleague. He offered advice when he could. The quality of his work gave no cause for concern. He was prompt, capable and hard working. He was conscientious and attempted to deal with calls in an expeditious manner, seeking to resolve issues raised at first point of contact. This led to him being questioned as to why his calls took longer than others.

[437] His call handling competence developed not as a result of training he received but through his own initiative. He was self-taught. He created his own *aide memoire*. He

took advice from his wife. PC Susan Pearson provided him with a document on the use of AVAYA. That document explained how to log on to AVAYA and a basic guide to its use. Susan Pearson talked Mr Henry through the system and alerted him to the importance of the After Call button. He had been caught out, on occasion, by failing to press the After Call Button timeously.

[438] From the outset Mr Henry used a Pot Book. He was not able to type as he spoke to the caller. He recorded details in his Pot Book and then created a STORM incident before moving on to the next call. Before creating any STORM incident he checked for associated reports on STORM. He noted the number of the caller immediately in case the call was lost. He usually recorded the last four numbers of the STORM reference number, when he created an incident. The Pot Book containing details of his shift on 5 July 2015 is a wire bound jotter he supplied himself. He generally destroyed his Pot Book after each shift. The one that contains the details of calls on 5 July 2015 is available because he had not got round to destroying it. He was never instructed in methods of reconciling the contents of his Pot-Book with actions taken at the end of a shift.

[439] After his initial shift Mr Henry worked the following shifts;

- Thursday 11th June 2015 16.00 hours - 21.00 hours
- Saturday 13th June 2015 16.00 hours - 21.00 hours
- Sunday 14th June 2015 16.00 hours - 21.00 hours
- Tuesday 16th June 2015 16.00 hours - 19.00 hours
- Thursday 18 June 2015 16.00 hours - 19.00 hours
- Tuesday 30th June 2015 16.00 hours - 19.00 hours

- Saturday 4th July 2015 10.00 hours - 14.00 hours

- Sunday 5 July 2015 10.30 hours - 14.00 hours

[440] Over the course of these shifts he considered himself to have become a competent but slow call handler and competent in the use of STORM. He judged that from his own perspective. He was given little feedback on his performance.

Calls dealt with by Brian Henry on 5 July 2015

[441] During his shift, between 10.30 hours and 14.00 hours, at Bilston on 5 July 2015 Brian Henry took eight calls for which he created STORM incidents. He dealt with more than these eight calls, but the precise number and timings cannot be established. AVAYA did not, then, have the capability to link incoming calls to a specific call handler.

[442] It is important to consider the timing and nature of the calls he dealt with in relation to the John Wilson Call 1 at 11.29 hours to see what, if anything, might explain his failure to action it or otherwise distract him. It also serves to demonstrate the diligence with which he undertook his duties.

[443] At 10.38 he took a call in relation to a complaint about a barking dog. The call is anonymous. There is an entry in his Pot Book, and a STORM incident created at 10.42 hours under reference 1467.

[444] At 11.06 hours he took a call in relation to concerns for a busker. He created a STORM incident at 11.13 hours and made entries on the STORM log until 11.20 hours. He recorded details of the call in his Pot Book.

[445] At 11.21.57 hours he took a call from a man in relation to a citation. The call ended at 11.22.12. He recorded the call in his Pot Book alongside the word '*Citation*'.

[446] At 11.27.56 hours he answered a call during which the caller made an enquiry about a relative. The call was terminated at 11.29 hours. No STORM entry was made. There is an entry in his Pot Book along with the caller's first name.

[453] The John Wilson Call 1 is made between 11.29.40 - 11.31.36 hours and is recorded in his Pot Book. There is no corresponding STORM incident.

[447] He answered a call at 11.33.48 hours, reporting a car accident in Falkirk. The call terminated at 11.44.25. There is an entry in his Pot Book. He created a STORM incident. This call is a relatively long call.

[448] At 11.44 hours he answered a call, reporting concern for a busker outside a restaurant. There is an entry in his Pot Book and he created a STORM incident at 11.47 hours.

[449] He answered a call at 12.03, reporting concern for a relative. The call is terminated at 12.09 hours as he deals with it. There is an entry in his Pot Book.

[450] He answered a call at 13.06, the caller reporting an assault upon her by a named individual. There is an entry in his Pot Book. He created a STORM incident at 13.10 hours.

[451] He answered a call at 13.23, reporting a suspected drunk driver. The call terminated at 13.26 hours. He created a STORM incident at 13.28 hours. There is an entry in his Pot Book.

[452] At 13:34 hours he answered a call and created a STORM incident at 13.40 hours. There is an entry in his Pot Book.

[453] On examination of Brian Henry's Pot Book, for this shift, notes relating to the eight calls for which he created a STORM report can be seen.

The John Wilson Call 1

[454] Brian Henry accepts the accuracy of the transcript of the John Wilson Call 1. In his Pot Book, there is an entry which reads *'…5212 John Wilson Chartershall Farm Stirling M9 Perth-Stirling Jct 9 south bound lane vehicle – sky blue, in bushes.'*

[455] Mr Henry was taken through the transcript. He acknowledged that he received details of a road traffic accident. He was given an accurate description of the locus. He was given a description of the colour of the vehicle and that it was partly hidden in trees and bushes. He did not ask for details of the registration number as he took from what Mr Wilson had to say that he couldn't see it. He took from what Mr Wilson had to say that there was no one in or around the vehicle and that the car had not recently come off the road. He assumed that it may have been there for some time. That assumption was based on Mr Wilson telling him the car may have come off the road the day before. He did not think that a car lying in trees and bushes at the side of the M9, absent any blue-and-white police tape, was a *'Red flag'*. He thinks from the evidence available to him that he assumed the car had been abandoned. That was his default setting. He was satisfied that there was no one in or around the vehicle requiring immediate assistance and there was no threat to life.

[456] His police training and experience told him that this was a matter requiring investigation. To that end he thinks, as he told Mr Wilson he would, he searched STORM for any earlier reports or information. At 11.33.23, 11.33.33, 11.34 and 11.36 hours, he conducted STORM searches. It is not possible to ascertain now to what these searches related.

[457] Investigators sought to identify the nature of the searches Mr Henry made on STORM around the time of the John Wilson Call 1. That proved fruitless. The National Command and Control Custodian for Police Scotland confirmed it was not possible. It was hoped that the data may be stored on the Police Scotland Oracle database which sits behind the STORM system. That data had been automatically cleared on 4th August 2015 when it reached storage capacity.

[458] Mr Henry appreciated that the John Wilson 1 Call must be acted upon. He assessed it as a Grade 2 call. He accepts he should have dealt with the call by checking STORM for any earlier incident and if there was no earlier STORM incident, create one.

[459] Mr Henry thought he may have created a Shadow incident, was then distracted and did not proceed to create a STORM incident. Shadow incidents are created when, for instance, details of the locus are unconfirmed. What details are known can be populated and are open to others who search STORM. The National STORM Administrator investigated this possibility but concluded that there was no '*Footprint*' of Brian Henry having done so and saw no circumstances in which it could have happened.

[460] Brian Henry did not deliberately ignore this or any other call he handled.

Possible explanation

[461] At his work station Brian Henry operated double screens and was familiar with doing so. When call handling he had open and available to him STORM, e-mails, GIS mapping and the intranet.

[462] Mr Henry is right handed. At his workstation he kept his Pot Book to his right hand side. His notes in relation to the call from John Wilson are the last entry on a page. The next page starts with an entry in relation to the phone call he took at 11.33.48 hours. If he had folded the pages over, then without retracing his steps the John Wilson entry would not be visible to him.

[463] An explanation offered by the Crown for Brian Henry not acting on the call is that after he ended the call, his investigations on STORM were interrupted by the relatively long call he took at 11.33 hours. Having taken that call and as a result of human error he forgot to enter the details of the call John Wilson Call 1 on to STORM. He then became involved in other phone calls for the remainder of his shift and never reconciled entries in his Pot Book with actions taken. He did not turn back the page.

[464] What in all probability happened is best summed up by Mr Sylvester-Evans; *'His distraction, probably created by the desire to provide a thorough account of any vehicle accident, was an 'act of omission' a 'lapse - a simple human error'.* Mr Sylvester-Evans cites the Health and Safety Executive publication HSG48, Reducing Error and Influencing Behaviour describing lapses as follows; '*Lapses cause us to forget to carry out an action, to lose our place in a task or even to forget what we intended to do. They can be reduced by minimising*

distractions and interruptions to tasks and by providing effective reminders especially for tasks which take some time to complete or involve periods of waiting. A useful reminder could be as simple as a partially completed checklist placed in a clearly visible location for a person doing the task.'

[465] Brian Henry was a credible, reliable and entirely honest witness. He is a confident, able and intelligent man. He took pride in his work. He cannot explain now, and could not explain in 2015 what caused him to fail to action the John Wilson Call 1 other than human error. It could be nothing else. It was not a conscious decision to ignore the call. There was much pathos in his evidence when, acknowledging that what happened was down to human error, he added; '*And I am that human*'. The tragedy for the families of John Yuill and Lamara Bell is that had his error been in relation to any other call that day and perhaps any call over the entire shifts he worked it would have had little or no consequence beyond inconvenience.

[466] Mr Henry's human error, was an error which any Divisional officer who volunteered for over time at Bilston using AVAYA could have made. The error was one which could have been made by any call handler at Bilston using AVAYA. That includes core staff who, frustrated with the reliability of ASPIRE, opted to operate AVAYA. The system Brian Henry was operating namely AVAYA and Pot Book, without any reconciliation of incoming calls with outgoing actions, meant that there was a risk of human error going undetected. In these circumstances calls may not be dealt with. That risk was never identified by Police Scotland at the time. Police Scotland failed to adequately train Brian Henry. He was inadequately trained in the use of

AVAYA prior to answering calls from the public. He was never trained in the use of ASPIRE.

[467] A reasonable precaution Police Scotland could have taken was to ensure that all call handlers, core or non-core were trained in and used ASPIRE at all times other than when it was unavailable, as envisaged in the Business As Usual plan. Had these precautions been taken, then they might realistically have avoided the death of Lamara Bell.

[468] Police Scotland, accept it failed to train Brian Henry and other non-core call handlers. As Chief Superintendent Paul Wilson put it Police Scotland did not '*invest*' in him. In short, Police Scotland's failings gave rise to circumstances in which such an error as made by Brian Henry could occur.

[469] The Crown, invite no criticism of Brian Henry. That view is echoed by all the other Participants and accordingly no criticism is made.

[470] Before leaving this chapter, the events of the afternoon of Wednesday 8 July 2015, from Brian Henry's perspective need to be considered. He was working his normal shift at Dalkeith when he received a call from Laura Henderson. By the time Laura Henderson made that call Police Scotland was aware of the contents of the John Wilson Call, and understood its significance. STORM had been checked for details of any recorded incident and none found. She was tasked by Chief Inspector Linda Russell to make contact with Mr Henry and find out if he remembered the call and what if anything he had done about it. She did so and Brian Henry confirmed that he had taken the call. The fact that John Wilson was a farmer triggered his recollection.

He said that once he had his Pot Book he would phone her back. He returned her call and confirmed that there was nothing in his Pot Book which indicated what, if any action, he had taken.

[471] While there is a difference in recollection as to the precise content of the conversation, he was advised, during a telephone call, that the blue Clio was one and the same car reported to him on 5 July 2015 and that one of the occupants was dead. The import of that information was not lost on him and he describes going into a state of shock. It was, he said, the worst call you can imagine as a serving police officer.

[472] Laura Henderson acknowledged Mr Henry's distress. She apologised to him at the time for delivering the news by telephone but said that it was a matter that needed dealt with urgently. Such was her concern for Mr Henry's welfare that she informed Chief Inspector Russell of his need for support.

[473] It is approximately 5 miles from Bilston to Dalkeith police station. Given the knowledge Police Scotland had at the time and the obvious effect imparting that information would have on Brian Henry, I find it reprehensible that a senior officer did not make the effort to meet with and question him in person.

35. Lessons Learnt?

Call handling in Bilston in 2014

[474] C3 Division and the call handling systems in place, particularly at Bilston, in 2024 is incomparable to that operated in 2015. That is as a result of the response by Police

Scotland to the tragic deaths of John Yuill and Lamara Bell. A response driven by HMICS.

[475] In July 2015, the Cabinet Secretary for Justice directed HMICS to undertake an assurance review of the operations, procedures and systems in place at C3 Division. The investigation was into the whole of the C3 Division, not solely Bilston.

[476] HMICS terms of reference were published on 22nd July 2015, and its aims stated as assessing:

1. The capacity of the systems and human resources available within the control centres to manage, receive, answer and prioritise calls.
2. The capabilities of the systems and the suitability of the training provided to those who manage, receive, answer and prioritise calls, and
3. The Process within the control room to ensure that all calls are handled and dispatched appropriately.

[477] After the initial investigation HMICS produced its *Independent Assurance Review Police Scotland – Call Handling Interim Report* dated September 2015. That report contained one Recommendation namely, that Police Scotland should consolidate and stabilise their staffing, procedures and systems in both the East and West Service Centres and ACR. While that stabilisation took place detailed planning should continue to be undertaken towards the end state model and the recruitment of staff accelerated.

[478] HMICS produced its *Independent Assurance Review Police Scotland – Call Handling Final Report* ('the Final Report') in November 2015 by which time a full complement of staff had been achieved at Bilston. This report was prepared by HMICS in the space of 4

months, testament to the diligence of the office and the cooperation it received from Police Scotland. The Final report, the preparation of which was overseen by Derek Penman the then Chief Inspector of Constabulary, made 30 recommendations, all of which were accepted by Police Scotland and discharged by May 2018. Of the 30 recommendations, the following are of particular interest to the Inquiry:

a. Recommendation 2 – Police Scotland review and identify learning from 999 call performance. Learning that can be taken forward in the planning and governance of stages 5, 6, and 7 of the C3IR Project.

b. Recommendation 5 – Police Scotland consolidate and stabilise its staffing, procedures, systems and processes in *inter alia* Bilston. While this is being done detailed planning for the end state model should continue.

c. Recommendation 7 – Police Scotland should appoint an experienced, qualified manager immediately to manage the remaining stages of the C3IR Project, and that key members of the Project Board be appropriately trained and experienced.

d. Recommendation 12 – Police Scotland develop a workforce planning model to support the C3 Strategic Vision and an evidence based assessment of staffing levels.

e. Recommendation 13 – Police Scotland review staff at the Information Resource Unit for call handling skills to ensure effective support and training is in place to maintain skills, awareness and understanding.

f. Recommendation 14 – Police Scotland develop a training strategy for the C3 division supported by a skilled and resourced national training unit.

g. Recommendation 16 –Police Scotland review the use of Pot Books and provide definitive guidance on their issue, use and supervision.

h. Recommendation 23 – Police Scotland define and document its key processes within C3 Division and update its SOP, with immediate investment in training and guidance for all existing and new staff.

i. Recommendation 24 – Police Scotland adopt a more formalised risk and vulnerability assessment model for call handlers incorporating both general and specialised awareness training.

j. Recommendation 25 – Police Scotland establish a Quality Assurance Framework to include regular call audits and the results shared with the SPA and local policing scrutiny units.

k. Recommendation 26 – Police Scotland should promote an improvement in culture whereby staff are encouraged to report adverse incidents or '*near misses*' and develop processes to capture, assess and implement any lessons learnt as a result.

l. Recommendation 30 – Police Scotland to ensure a clear and consistent vision for the role, responsibilities and resourcing of the National Systems Support function.

[479] On receipt of the Final Report the Cabinet Secretary updated the Scottish Parliament and instructed HMICS to undertake a programme of ongoing assurance

work. HMICS continued to monitor progress and assess levels of risk within the C3 Division, by way of unannounced visits to Service Centres.

[480] In January 2017, HMICS published its *Independent Assurance Review - Police Scotland Call Handling Update Report*. The report acknowledged good progress by Police Scotland. It recognised the successful delivery of a number of recommendations including the implementation of a virtualised Police Scotland Service Centre and the upgrading of key ICT systems.

[481] In May 2018 HMICS published its *Call Handling Update Report* and made a further 8 recommendations, all of which were accepted by Police Scotland and all have been discharged. Of those 8 the following are of interest to the Inquiry:

(i) Recommendation 1 – Police Scotland develop a route map for ICT development and investment in C3 systems as soon as possible to secure medium to long term investment in what is a critical area of policing.

(ii) Recommendation 2 – Police Scotland develop a C3 Procedures manual.

(iii) Recommendation 5 – Police Scotland and the SPA adopt a C3 governance, programme management and quality assurance approach as standard in implementing significant change programmes.

(iv) Recommendation 6 – Police Scotland develop a risk and vulnerability model to support the most appropriate response to the wide range of demands for assistance. The role of PAD in particular to be reviewed.

(v) Recommendation 8 – Police Scotland should ensure that C3 Division develops its approach to continuous improvement and maintain investment in its governance and business development teams.

[482] In August 2022, HMICS made a further 8 recommendations all of which were accepted by Police Scotland which continues its efforts to discharge them. The following recommendations are of interest to the Inquiry:

(i) Recommendation 2 – Police Scotland should broaden the training and support for call handlers by including inputs from specialists to ensure that they can better understand investigative opportunities, vulnerabilities and engagement when assessing callers needs through THRIVE.

(ii) Recommendation 3 – Police Scotland capture failure demand rate through the C3 Division to ensure that a quality service is delivered to the public through CAM.

(iii) Recommendation 7 – Police Scotland improve the resilience and capability of its ICT systems to ensure that C3 Division staff have access to information required to perform their roles.

[483] There is no set time scale for recommendations to be discharged once accepted. The nature of the recommendations meant that some could be discharged relatively quickly whereas others, requiring systemic and structural change, took longer. The complexity of any Recommendation and resources available to Police Scotland are factors determining the time needed to implement it.

[484] In order to satisfy HMICS that a Recommendation has been discharged Police Scotland prepares and submits an Action Plan setting out how it intends to do so. Work to that end is monitored at regular meetings between Police Scotland and HMICS. Police Scotland submits an Evidence Submission Form vouching their work in. HMICS considers the evidence and if satisfied discharges the recommendation. The process is designed to be collaborative and to enable recommendations to be implemented as efficiently as possible. A discharge is not granted until HMICS are satisfied on an evidential basis that it should be.

[485] HMICS continues to meet with Police Scotland and continues to monitor its progress in relation to outstanding recommendations.

[486] The Crown invites the Inquiry to conclude that since 2015 Police Scotland has made significant progress in the reform of its call handling processes and has co-operated fully with HMIC. I have no doubt that is so. The conclusion of Ms Galbraith, KC's submissions summarise the conclusions that the Inquiry must reach in this regard as follows:

> "Since the tragic circumstances of the deaths of John Yuill and Lamara Bell, HMIC have demonstrated a dedication and commitment to assess, monitor and support Police Scotland, in order to deliver effective and efficient policing. Every opportunity is taken through its quality assurance work to test and improve C3 systems to ensure that they meet the highest possible standards. Further, Police Scotland have demonstrated positive engagement with HMICS, and have uniformly accepted, and worked, to implement all their recommendations."

[487] I conclude, as invited to do by the Crown and Ms Galbraith, KC that the Inquiry can have confidence that HMICS and Police Scotland have fully co-operated with each

other and that Police Scotland embraced the recommendations when reforming its call handling systems.

The reformed Bilston

[488] Before setting out the present systems in place at Bilston I take this opportunity to thank Chief Superintendent Paul Wilson for arranging a site inspection of Bilston for me. I was afforded access to the Service Centre and the opportunity to watch and listen to call handlers dealing with live calls. I observed the ACR and how it dealt with incoming STORM incidents.

[489] Paul Wilson has been the Chief Superintendent for C3 Division since 23rd May 2022. As Chief Inspector, he was the West Area Commander for ACR from 2014 – 2017. On promotion to Superintendent he was embedded with the Emergency Services Mobile Communications Programme from 2017 – 2019. The ESMC programme involved the development of the new National Communications Network to host all emergency services. From there he was posted to the Operational Support Division with responsibility for Contact, Command and Control before taking up his present post. I set out CS Wilson's CV in order that his expertise in Contact, Command and Control is appreciated. He provided the Inquiry with an overview of the key changes and the way in which risk is managed and mitigated.

[490] In April 2016 a Notable Incidents Process ('NIP') was implemented to address Recommendation 26 of the Final Report. That process captured incidents or 'near misses'. What is learned from these directs additional training or changes to processes.

A Governance and Improvement Unit ('GIU') was established to review each notable incident. Staff were encouraged to, and did, develop the confidence to self-report mistakes and to challenge custom, practice and processes. This process afforded C3 Division with empirical data enabling change and improvement in the service it offers the public. By reviewing all Notifiable Incidents the GIU is able to design and tailor appropriate training courses. Good work and good practice is recognised and shared amongst the C3 Division staff as a learning tool.

[491] Recommendation 14 of the Final Report proposed that Police Scotland develop a training strategy for C3 Division supported by a skilled, single national training unit. A Leadership and Development Unit was established along with a bespoke C3 Division training programme. The training of call handlers, ACR staff and the Resolution Team is now formalised. All staff are required to complete the course and pass an assessment prior to being allowed to operate in the Service Centre.

Service Centre Training requirements – call handler.

[492] The call handler training course lasts eight weeks. It requires candidates to be trained in key Police Scotland Systems, ASPIRE and STORM. The use of ASPIRE is mandatory other than when Business Continuity Procedures are necessary. The first four weeks of the course is classroom based, learning systems and procedures. At the conclusion of this section the recruit's abilities are assessed. If the assessment is passed the recruit progresses to the Service Centre Training Academy for a further four weeks during which they are monitored and assessed handling 101 calls. At the end of the

Academy training the recruit joins a team. Over the course of the next three months the recruit handles 101 calls. During that time five calls per month are assessed. If these calls meet the quality assurance requirements, the recruit is then trained over a period of three days to take 999 calls. The recruit then takes 999 calls for a period of four weeks during which five calls per week are assessed. At the end of that process if the recruit is approved by the Service Centre Operational Manager they will be confirmed in the role of call handler. Police Scotland have created a rigorous skills based training programme.

Service Centre Training Requirements – Area Controller.

[493] Area Controller training is a four week course on STORM and the Integrated Communication and Control System. The training is practical and provides an operational context for the controller. Throughout the course the candidate is mentored. The ability to effectively command and control any given situation is multifaceted and so the ACR course is demanding. It is not uncommon for candidates to fail.

[494] All staff training records are kept and govern when they require training or retraining. Absences, secondments and current skills are all monitored with a view refreshing diminishing skills. There is a system of continued professional development at work for all C3 Division staff.

Risk assessment - THRIVE

[495] Recommendation 24 of the Final Report proposed that C3 Division adopt a more formalised risk and vulnerability assessment model when handling calls. In June 2019, Police Scotland introduced the Contact Assessment Model ('CAM'). This replaced the grading system when assessing risk in calls from the public. The previous grading system was a limited tool to assess risk and determine response. To support CAM Police Scotland introduced an enhanced assessment model known by the acronym THRIVE. The THRIVE assessment is used in conjunction with ASPIRE prompts to enable an accurate assessment of the caller's needs and vulnerabilities. THRIVE is the model used by C3 Division to assess all contact with it and to identify the most appropriate response. The intention is to create consistency in decision making. All C3 Division staff are trained in the application of THRIVE. That training consists of:

(i) An overview of the process and its purpose.

(ii) A breakdown of the six component parts.

(iii) The four resolution options available to the call handler.

(iv) How to apply a THRIVE assessment to reported incidents.

Only on successful completion of training and subject to assessment can officers and staff take up their posts.

The six elements of THRIVE

[496] The six elements comprising THRIVE are:

T - THREAT. The call handler assesses what threat is posed to people, property, public safety, and community cohesion.

H - HARM. The call handler assesses whether the threat has realised or the situation is deteriorating and what the potential for harm is.

R - RISK. The call handler identifies the likelihood that the identified threat will occur.

I - INVESTIGATION. The call handler considers whether there is a crime in progress; has it been recently discovered; can forensic evidence be recovered; is a known offender involved; the value of property involved and if CCTV can assist.

V - VULNERABILITY. The call handler considers the family or personal circumstances of anyone involved in the call. Consideration is given to any disability, equality or diversity issues and economic circumstances.

E - ENGAGEMENT. The call handler must manage the caller's expectations and provide realistic outcomes, timescales and courses of action.

[497] The call handler must create an incident log which identifies where the THRIVE assessment has been carried out be it the Service Centre, ACR or Resolution Team. The grading of the call must be recorded as:

(i) Immediate - where the circumstances identify a threat to life, property or an ongoing incident and the police response requires to be dynamic.

(ii) Prompt - resources should be dispatched as soon as possible with a supervisor reviewing the incident after 45 minutes.

(iii) Standard - a Local Policing Appointment will be made, and

(iv) Other Resolution - advice is given. The Resolution Team, formerly the PAD team, provide advice and seek to resolve calls over the telephone at first instance or by way of face-to- face appointments or where available by video link.

[498] THRIVE is designed to be used in conjunction with ASPIRE which, following an upgrade, has further inbuilt safety functions and functions to assist the call handler determine the grading of the call. When a call is received it is recorded. The call automatically opens a window in ASPIRE which logs the call and populates the caller's history, if the caller has contacted Police Scotland on that device before. The window cannot be closed without a log being created. The log requires an update in relation to any decision made in relation to the current call. At the conclusion of the call the call handler must record all actions on ASPIRE. If no police action is required that must be recorded on the log. The information once entered cannot be deleted. If police action is needed the call handler automatically generates the incident onto STORM. Key mandatory fields require to be completed before the STORM incident is transferred to the ACR. Once created this incident cannot be deleted and to close the incident requires a mandatory update and closure code.

[499] When selecting an incident type the call handler has the benefit of a drop down box which provides a STORM code. For example, if the caller is reporting a missing person STORM code PW-25 is selected. The call handler is then provided with a series of prompts to assess and grade the call. These prompts are not exhaustive but are fairly

comprehensive. Using a missing person call as an example the call handler is provided with the following prompts:

- Confirm reporter's name, address, tel no, location and relationship to the MP
- Physical description inc clothing
- Details of time and place MISPER last seen
- Emotional state when last seen
- Previous self-harm/suicidal tendencies
- Additional concerns e.g. drugs, alcohol, special needs, medication
- Have they gone missing before? If so where were they located?
- Access to funds
- Access to a vehicle/bus pass/passport

IF REPORTED MISSING FROM HOSPITAL

- Obtain ward no/location/staff members name & contact no
- Has the MP to be returned? If NO ask why they are reporting the patient missing
- If YES, establish the reason they are to be returned
- Are they a detained or restricted patient
- Medication? If yes obtain details
- CCTV
- Were NHS protocols carried out prior to contacting Police
- Have NHS missing patient & risk assessment forms been completed

- Has the Hospital General Manager and Clinical Co-ordinator been informed
- **IMPORTANT- if NHS Misper protocols have not been followed we WILL still raise an incident however you should note the above for ACR information**

IF REPORTED MISSING FROM A CHILDREN'S HOME/SECURE UNIT

- Regular absconder? Do they normally return of their own accord?
- Code Low/Medium/High risk
- Warning signals
- Considered a danger to themselves/ other
- A legally detained person – if so, under what grounds

ARE ANY OF THE FOLLOWING PROTOCOLS IN PLACE FOR THE MISPER?

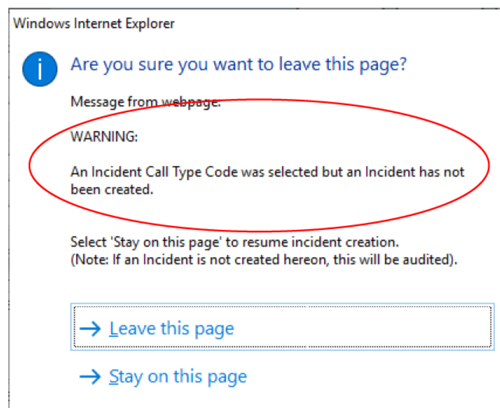
- Herbert (elderly persons with dementia)
- Philomena (young person in care home/foster)
- Autistic MP Protocol (any persons with autism)
- If the above applies – where are the forms held
- Refer to C3 Procedures for full details
- C3 Procedures Guide – Missing Persons

[500] The comprehensive nature of the prompts together with the intensive training of call handlers leads me to reject the submissions from Mr Brown, KC that recommendations be made for specific questions to be asked when call handlers are

dealing with a car reported as off the road. I accept the Crown's submission that to do so is too prescriptive.

[501] Once the assessment is complete and the grading chosen the call is transferred to the ACR. The ACR has the opportunity to review the grading and the appropriate police response.

[502] Importantly, should the call handler select '*end task*' before the incident is transferred to the ACR they are confronted with the following pop-up box;


Windows Internet Explorer

Are you sure you want to leave this page?

Message from webpage:

WARNING:

An Incident Call Type Code was selected but an Incident has not been created.

Select 'Stay on this page' to resume incident creation.
(Note: If an Incident is not created hereon, this will be audited).

Leave this page

Stay on this page

[503] As recommended in the Final Report, Recommendation 25, in order to improve the service it provides, C3 Division created a Governance and Improvement Unit. The unit is a dedicated Quality Assurance Team charged with conducting audits of call handling throughout C3 Division. Each call handler and Controller is subjected to two call audits per month. The unit conducts targeted or reactive assurance reviews and produces a monthly Quality Assurance Report.

[504] The use of what are termed '*ad hoc*' Pot Books by call handlers and Controllers is no longer permissible conform to Recommendation 16 of the Final Report. Pot Books are used in at Service Centres but are strictly controlled. What Police Scotland term

'*Workbooks*' are personally issued to staff with a unique identity number and subject to audit. They cannot be destroyed and are retained by Police Scotland. Call handlers and Controllers are not at liberty to record information on any other document or paper. In the event that Business Continuity Processes are instigated then any paper logging must be done on the official Workbooks.

[505] C3 Division now relies on complex, sophisticated ICT systems. HMICS Recommendation 30, identified the need for a clear and consistent vision for the National Systems Support to include both resources and responsibilities. Accordingly, Police Scotland created the C3 National Systems Team, headed up by a Superintendent and 25 staff who oversee and ensure that AVAYA, ASPIRE, STORM and ICCS are supported operationally. The team rigorously test any new system or system updates to ensure that it functions properly before it is operational. The team operates in conjunction with the Digital Division and Programme Management Office to ensure that any ICT change or upgrade is operational and fully understood by staff before it is approved for use.

[506] To ensure that staff have a proper understanding of the range of tasks that can be demanded of them, and the resources available to meet those demands the C3 Division Manual was developed, as per Recommendation 2 of the HMICS Update Report. It is an A-Z reference manual. The manual is constantly updated taking account of, amongst other things, the NIP. The manual is available to staff at all times.

[507] HMIC recommended that Police Scotland have a forecasting and planning tool to identify likely demand and the requisite level of resources to meet that demand. Police

Scotland now use an analytical system called Total View. Total View reviews previous demand for policing, and other intelligence, to forecast future likely demand. A more enhanced system will be available to Police Scotland in the near future.

[508] A significant problem in 2015, contributing to the poor performance at Bilston was the lack of staff and the inability to recruit staff. Recommendation 12 of the Final Report identified the need for Police Scotland to develop a planning model to support C3 Strategic Vision and provide an evidence based assessment of staffing levels. Police Scotland instigated a dedicated People Plan aligned to the wider Police Scotland Strategic Workforce Plan. In terms of these plans the staffing levels are independently reviewed. Additionally, Police Scotland maintains a Senior Management Succession Plan to ensure an experienced body of senior officers available to assist when required and to ensure continuity in the management of C3 Division. All future staffing needs and recruitment take account of the training programme timescales.

Observations

[509] The observation that C3 Division and the call handling procedures in 2015 are incomparable with the procedures in 2024 is an understatement. Laura Henderson described Bilston, on her arrival as Service Centre Manager, as '*underdeveloped*'. That too is an inadequate description. The changes made by Police Scotland following the recommendations of HMICS has created an entirely different workplace. CS Paul Wilson was an outstanding witness and professional police officer. It is

appropriate that the last words on the present state of C3 Division are left to him, they form a succinct summary of the turnaround;

> "The cumulative impact of these recommendations has undoubtedly improved C3 Division. Considerable investment in divisional infrastructure has taken place establishing functions to manage systems, resourcing and to support governance and improvement.
>
> Key enablers that sustain safer working practices such as training, quality assurance and audit have been fully embedded ensuring that any learning identified from Notifiable Incidents can be swiftly implemented. Importantly the introduction of the Contact Assessment Model has changed the operating model of the Division providing alternative resolutions beyond the immediate dispatch of officers. The introduction of THRIVE assessments has ensured that advisors and controllers are focussed on what outcome is best for the caller as opposed to that being decided by previous default settings on the Command and Control system.
>
> To conclude, the implementation of the 2015 HMICS Independent Call Handling Review Report also created an organisational culture were openness is valued, learning encouraged and our staff feel confident to admit mistakes. All of these improvements to the infrastructure, systems and culture have supported C3 Division in making solid progress and supported us to create an operating environment that is focussed on service delivery and continuous improvement."

[510] The public can be confident that C3 Division has been transformed into an efficient, tightly controlled and sophisticated complex of Service Centres all capable of communicating with each other on a unified IT network. The restructured C3 Division is better able to serve and protect the public than the one that Brian Henry volunteered for in 2015. It is not risk free. It still has a susceptibility to human failure but the risk of human failure and that failure going undetected is now marginal.

36. Submissions

[511] Given the passage of time and the cooperation of all Participants and their representatives there was little by way of dispute to resolve. In the body of this Determination I have addressed most of the parties' submissions. I now address what limited matters of dispute remain and to put, in short form, any observations or commentary that the parties consider important to make.

Should the closure of Stirling or Glenrothes have been delayed?

[512] The Crown suggest that delaying the closure of either or both Stirling and Glenrothes until Bilston had the requisite staff to cope with the increase in business, the tripartite system was embedded and call handlers trained in its use, may be something that the Inquiry wishes to consider. It suggests that it may have been a precaution Police Scotland could reasonably have taken, and if taken might realistically have avoided the death of Lamara Bell. The Crown's logic comes to this, if that precaution had been taken then the use of Divisional officers would have been unnecessary. The John Wilson Call 1 would have been handled by a core call handler operating ASPIRE. While ASPIRE is not failsafe, the risk of a STORM incident not being created was significantly less than when operating AVAYA and a Pot Book. It was then more likely that the call would have been actioned and resources deployed to the locus at some time during Sunday 5 July 2015. Lamara Bell would have been rescued from the blue Clio and medical treatment commenced. In that event she would have survived the injuries sustained in the accident.

[513] A delay in the time line for Bilston was considered by ACC Thomson in late 2014. The context of how that may have been done and the implications of any delay on the C3IR Project was left unexplored. The matter was not raised again until the Gold Group meeting on 24th April 2015, when CS Speirs informed the group that the C3IR Project was under review, that it would not change but that '*the timescales may lengthen*'. By this time both Stirling and Glenrothes had closed and so it is difficult to understand what timescales he is referring to and how that may assist Bilston.

[514] The length of time allowed for the implementation of the tripartite system was ambitious and required to driven hard to achieve, and in the event over ran. The closure of Glenrothes was pivotal to determining staffing levels at Bilston. Until the redundancy process concluded the precise number of call handlers willing to relocate could not be known.

[515] Ms McCall, KC submits that there is no proper evidential basis to conclude that pausing or postponing the implementation of stages 2, 3 or 4 of the C3IR Project was a precaution that could reasonably have been taken. I agree. The only support for the Crown's submission comes from Laura Henderson who considers that the whole process was too fast and should have been slowed down to enable an assessment of it at each stage. She considers that there was insufficient preparation made to stabilise Bilston before it had to cope with the increased volume of calls from Glenrothes.

[516] Mr Sylvester-Evans is less certain and his opinion is couched in ambiguous terms. His view is that any practical extension or delay of the C3IR Project would have to be considered at an early planning stage. By that I presume he means that

contingency plans would have to have been considered, at the planning stage in 2013. That was not done, and by 2015 although there were issues with recruitment and IT these issues were being addressed. It was anticipated that the recruitment campaign would fill the vacancies. The vacancies, permanent or otherwise may well have been filled but for the 'hiatus' in January, February and March 2015.

[517] Mr Sylvester-Evans viewed any delay to the C3IR Project as *'difficult decision'* and *'politically sensitive'*. Politically sensitive in the sense that it would have been perceived as delaying the cost benefits of the C3IR Project. His opinion is that Police Scotland did not fall significantly short in the planning and oversight of the C3IR Project and that the use of Divisional officers was a reasonable and sensible stop-gap pending the full complement of call handlers being available.

[518] Reservations over the political sensitivity of a delay to the C3IR Project is not a matter for this Inquiry. Even though I might imagine a delay would be detrimental to the cost benefits of the C3IR Project, there is no evidence to that effect. There is no evidence as to the effect any delay may have on the redundancy processes undertaken. There is no evidence as to when such a delay should or could have been implemented effectively. By May 2015, it was too late, as Mr Sylvester-Evans says by that time the *'die was cast '*. He suggests that if a delay was reasonable then it should have been before the closure of Stirling and Glenrothes. That however ignores the agreed evidence that until the closure of Glenrothes, the full needs of Bilston could not be accurately assessed. There is no evidence as to how long the delay to the closure of Stirling and Glenrothes would need to be. Would it be until the tripartite system was integrated throughout C3

Division? Would it be until the full complement of staff arrived trained and ready to go at Bilston? If so when would either or both of these situations occur? There are too many imponderables enabling me to conclude that delaying or pausing the C3IR Project would have been a reasonable precaution.

[519] As submitted by Ms McCall, KC if Stirling had remained open, and was open at 5 July 2015, it would have handled the John Wilson Call 1. Stirling did not operate a CRM. It had no system of reconciling Pot Books. Accordingly, the same human error that led Brian Henry to not create a STORM incident could be made there. If Stirling had closed and Glenrothes remained open, it may have taken the call John Wilson Call 1. Glenrothes did not operate a CRM. The risk that any call did not give rise to a STORM incident is then similarly live.

[520] Accordingly I cannot conclude that a delay or pause in the implementation of Stages 2, 3 or 4 of the C3IR Project until Bilston had sufficient numbers of trained core advisers to meet demand would have been a precaution reasonably taken by Police Scotland.

[521] While it has no bearing on whether a delay would have been a reasonable precaution, the SLB or the Chief Constable could have taken that decision. To do so needed accurate, up to date information as to the state of Bilston and the progress of the C3IR Project after the closure of Stirling. That information was not made available to them. The SPA were in the same boat, judging from its reaction to the news delivered by ACC Thomson as to what she had uncovered.

What is considered a system of work?

[522] The Crown submits that the C3IR Project, in itself, was a system of work in that it was a system of call handling reform. A system of work that was defective in that the system was pursued in a manner that gave rise to foreseeable staff shortages. The deployment of Divisional officers arose as a consequence of the defects in the C3IR Project system of work.

[523] A number of problems arise with the Crown's submission on this point. Firstly I agree with Ms McCall, KC when she submits that the relevant system of work was the call handling process and not the C3IR Project at large. The C3IR Project, as can be seen from its Terms of Reference and Strategy Document, is about more than call handling. Call handling is the operational side of C3 Division. It is the failure of the system of call handling that created the factors which contributed to the death of Lamara Bell. It was the failure to ensure that Divisional officers were trained in ASPIRE and operated all parts of the tripartite system when call handling that contributed to the death of Lamara Bell.

[524] The use of the tripartite system was departed from as a result of the decision taken by Inspector Kerr, but officers, more senior to her, and senior management were told by her that the training of Divisional officers was on AVAYA. I agree with Ms McCall's submission that the most senior officers, ACC Thomson and CS Speirs were not aware of her decision. Not only were they unaware, they would not have envisaged a situation whereby call handlers, Divisional or otherwise would be working in a Service Centre and not trained in all elements of the tripartite system.

[525] Ms McCall, KC seeks to separate CS Craig Naylor and CS Alan Speirs from Police Scotland and them as individuals when considering the failure to recognise the risk inherent in the non-use of ASPIRE. As she points out, and I accept, there is evidence before the Inquiry that those who designed the tripartite system and those who ran C3 Division at the relevant time did recognise the risk. She invites the Inquiry to conclude that CS Speirs and CS Naylor recognised the need for training in all three parts of the system, the risks associated with insufficient training in all three parts of the system, the need to operate the whole system and that they were unaware of the departure from the tripartite system following the decision of Inspector Kerr. I agree and conclude, that the understanding or awareness of the risk of not using ASPIRE was not uniform across the organisation of Police Scotland.

[526] I do not accept the Crown's submission that the system of working was the C3IR Project. I conclude that the relevant system of working is the call handling process. The call handling was a defective system of work and the appropriate findings are made.

Submissions on behalf of Andrew Bell

[527] Mr Brown, KC invites the Inquiry to make a Recommendation on the specific nature of questions asked when a caller reports an apparently abandoned car. He makes that submission in light of the content of the John Wilson Call 1. What is submitted is that the following questions be asked:

1. Can you see the car?
2. What is the registration number of the car?

3. Is anyone in the car?

In the event that the caller cannot confirm that there is no one at or around the car then police officers should be dispatched immediately.

[528] Mr Brown accepts that the THRIVE risk assessment coupled with the proper use of ASPIRE and the rigorous training undertaken by call handlers makes it certain that the John Wilson Call 1 would be handled quite differently and better. I do not share Mr Brown's concerns that a call handler could be headed down the track of thinking that the car was abandoned. Accordingly while I appreciate Mr Brown's submission I do not think it necessary to make the Recommendation he suggests. I agree with the Crown's assessment of such a recommendation, given the current systems in place at Bilston, as too prescriptive.

Submissions for Gordon Yuill

[529] Mr McConnachie, KC accepts that John Yuill was responsible for the accident in that he was the driver of the blue Clio and that for whatever reason the car left the road. I have addressed his submissions in relation to the cause of the accident and his criticism of PC McEwan's report and opinion.

[530] Mr McConnachie submits that the length of time the police investigation and the legal proceedings have taken is far too long. During that time Gordon Yuill has suffered considerable upset and Press intrusion causing him poor health. Very sadly John Yuill's step mother, Anita Dollard, who he regarded as a mother figure passed away on 24th November 2022. Her passing was prior to the start of the FAI. I know from

Mr McConnachie and the Crown that Anita Dollard had an active interest in the FAI and was wholly supportive of Gordon Yuill's interest in it. I pass on my condolences to him and his family for their sad loss. I appreciate that the length of time it took to commence this Inquiry has taken its toll on Gordon Yuill and his family.

Submissions for Michaela Kerr

[531] There is no need for me to rehearse the submissions made on behalf of Inspector Kerr. They are well made and have been taken into account when determining her role in the events leading to the accident.

Submissions for Brian Henry

[532] There is no need for me to rehearse the submissions made on behalf of Brian Henry. They are well made and have been taken into account when determining his role in the events leading to the accident.

Submissions for Police Scotland

[533] The submissions for Police Scotland are a statement of lessons learnt and steps taken by the organisation since the accident. Much of what is said is covered in this Determination. Additional information is provided as follows:

1. In so far as the MISPERs are concerned Police Scotland is drafting a policy designed to ensure that officers are aware of the value of data from all

Safety Camera units and that such data is available 24 hours a day, seven days a week.

2. There are no volunteer Divisional officers call handling in C3 Division. That practice ceased after the failure to action the John Wilson Call 1.

3. In 2022 Police Scotland received around 2.8 million phone contacts. Around 1.8 million were 101 calls and 1 million 999 calls. That equates to an average of 49,315 calls per day. In 2023, the number of 999 calls increased by 18%. Addressing these calls takes longer using the THRIVE model, however call satisfaction rates remain high.

4. The Chief Constable confirms Police Scotland's commitment to improving the wellbeing of all people, places and communities in Scotland. In doing so she undertakes to take on board the Crown's submissions in relation to the future replacement of ASPIRE.

Submissions for HMICS

[534] I am grateful to Ms Galbraith, KC for her summary of the involvement of HMIC and the cooperation it received from Police Scotland during it investigations. I agree with her conclusion that HMICS have demonstrated a commitment to assess, monitor and support Police Scotland to deliver effective and efficient policing.

37. Delay

[535] Both CI McDowall and CS McCreadie acknowledged that the passage of time, four years, between the accident and 2019 affected their memory of events. The commentary of both officers puts into context the practical effects of delay in commencing proceedings, namely that even highly trained, skilled witnesses forget things. It is imperative that a Fatal Accident Inquiry should commence as soon as reasonably practicable.

[536] The delay in bringing this matter to an Inquiry has been addressed by the Crown. The Crown commences its submissions with the following; '*The Crown acknowledges the overall time taken to conduct the investigation, conduct criminal proceedings and commence the Fatal Accident Inquiry in respect of the deaths of John Yuill and Lamara Bell'.* It recognises that the overall time taken to reach the Inquiry will have had an impact on the families of both. The Crown submission does not offer its opinion as to whether or not the time taken was too long. It sets out the steps taken to reach two stages, the prosecution of Police Scotland and then this Inquiry.

[537] The criminal investigation into the accident is properly described as a large-scale, complex and unique criminal investigation. Many expert reports were commissioned. The medical evidence as to the survivability of Lamara Bell was a matter of dispute until the final days of the Inquiry. Health and Safety issues had to be investigated. All that accepted, that it took six years and two months from the date of the accident to the conviction of Police Scotland strikes me too long, notwithstanding the detailed time-line proffered by the Crown.

[538] The Inquiry is more concerned with the time it took to decide that a FAI should be held. It would appear from the time line that it was not until January 2021 that consideration was given to a Discretionary FAI. It must have been patently obvious that the events leading to the John Wilson Call 1 being mishandled caused serious public disquiet. Whatever determined the decision to prosecute Police Scotland had no bearing on the decision to hold a FAI. The PIRC Supplementary Report dated June 2016 makes clear that the criteria for holding a Discretionary FAI was met. Add into that the Chief Constable's public announcement in July 2015 that his Force had '*failed*' John Yuill and Lamara Bell it is then a puzzle as to why it took until November 2021 for Crown Counsel to instruct that an Inquiry be held.

[539] The criminal investigation was being conducted by the Criminal Allegations Against the Police Division ('CAAPD) while the Fatal Accident Inquiry was being prepared by the Health and Safety Investigation Unit (HSIU') of Crown Office. The Crown submission states that the time-line discloses joint working between these two dedicated teams. However, only in November 2021, some six years after the accident did the HSIU commence preparatory work for the FAI. That preparatory work included considering all of the evidence obtained over the course of the criminal investigation. That can hardly be said to be joint working.

[540] The Crown accept that changes to the way COPFS now work should help to reduce the time taken to conclude large scale and complex cases. It now operates in accordance with a formal joint working process. Specialist teams in Crown Office and dedicated Crown Counsel conduct investigations in tandem through a formal parallel

investigation procedure. That procedure is overseen by senior management through Case Management meetings. The process is designed to allow the preparation of criminal proceedings and FAI to be done at the same time and as a result reduce the delay in commencing a FAI.

[541] All of that said, there is no concern over is the way in which the FAI was conducted from 2022 onwards. It was a model for how a FAI of this complexity should be organised, managed and presented.

[542] SCTS and the TC&F Business Manager Danielle Blue played a pivotal role in ensuring the smooth running of the Inquiry in:

1. Identifying and equipping a repurposed court room in Falkirk Sheriff Court to accommodate it.
2. Equipping the court room with IT enabling the Inquiry to be run on a paperless basis.
3. Dedicating a Sheriff Clerk, Ailsa Ure, to the Inquiry on a full time basis supported by Eilidh Thomson.
4. Dedicating Neil Seath, Bar Officer, to the Inquiry. Mr Seath ensured that the IT systems ran without a glitch and he was helpful to all parties throughout the Inquiry.

[543] Into that mix goes the cooperation and goodwill of all the Participants and instructed Counsel. Their dedication, professionalism and preparation made what was an extremely complex FAI manageable.

38. Closing remarks

[544] This dreadful incident has taken nine years to conclude. During that time there has been exhaustive investigations by HMICS, COPFS, PIRC and two independent experts. The amount of documentation in the form of productions and labels is extraordinary. The Inquiry was originally expected to last twelve weeks. That projected timescale was reduced to eight and in the event the Inquiry took five weeks.

[545] The explanation for what happened after the John Wilson Call 1 was clear from the moment PIRC concluded its investigation and certainly from the time of HMICS Final Report. It could be said that it was clear from the moment the John Wilson Call 1 was discovered and Brian Henry confirmed that he had not actioned it. It would be wrong to interpret that as blaming Brian Henry.

[546] Brian Henry was inadequately trained and left largely unsupervised to operate a system that allowed for human error to go undetected. His human error going undetected meant that Lamara Bell was left in a vehicle by the side of a major motorway in Scotland suffering devastating injures. These injuries, together with the delay in rescuing and treating her led to her death.

[547] Police Scotland are under intense scrutiny at the moment for a number of matters, none of which concern this Inquiry. The public must be tired of hearing the trope *'Lessons will be learnt'* when major organisations such as Police Scotland are found wanting, only to discover that nothing has changed. That is not so in this case. C3 Division of Police Scotland is an entirely different organisation now than it was in 2015. It is led by a dedicated, professional team of Police Officers and civilian staff. It is run,

as it should be given the responsibility it carries, on the lines of a large corporate organisation.

[548] In its closing submission the Crown asks the Inquiry to accept the evidence of CS Paul Wilson when he confirmed that ASPIRE is an ageing system and will be replaced by a new CRM. That new CRM will offer greater functionality. What is clear from the evidence of CS Wilson is that the planning for the introduction of the new CRM will be a sophisticated exercise undertaken on a commercial basis involving consultation and tendering. All lessons learnt from the accident will influence that planning and implementation. The Crown do not ask that any formal recommendations be made but that the Inquiry should "*Encourage Police Scotland to fully embrace any increased functionality which a new CRM system might bring, so as to increase operational effectiveness and minimise further risk of innocent human error impacting upon service delivery, all against a background of continuing HMIC oversight into C3 Division by HMICS well into 2024 and beyond."* It goes on to suggest that Police Scotland is encouraged to make some incident prompts mandatory and that a '*time trigger*' is utilised to alert Team Leaders to unactioned or delayed calls.

[549] Police Scotland are to be encouraged to do as suggested by the Crown when replacing the CRM. The Inquiry does no more than that. The minutiae of future IT systems is not a matter for the Inquiry. Provided procurement of the replacement system is carried out in the manner described by CS Wilson then any new CRM will be fit for purpose and designed by IT experts. Substantial improvement in the IT systems will be seen provided officers of the calibre of CS Wilson manage C3 Division. As far

back as the Final Report, Derek Penman HM Inspector recognised the need to assure and scrutinise progress of the key ICT systems independently. He considered that Police Scotland had the opportunity, in future planning its ICT systems to become a class-leading service. He outlined the need for Police Scotland and the SPA to learn from their experiences to date and to "*Ensure that robust governance, programme and programme management, staff engagement and independent review are core elements of their approach to the delivery of significant and complex change in the future.*" On the evidence, it is fair to say that Police Scotland has responded positively in that regard.

[550] It cannot be said that human error is entirely removed from the current system, but Police Scotland and the experts who have considered their present and future operations are confident that the type of error that led to the deaths of John Yuill and Lamara Bell being repeated is remote. So remote that only wilfully ignoring a call would give rise to a call going unactioned. It follows then that lessons have been learnt and that the public should have confidence in C3 Division's ability to respond to calls made. The response to any call is of course dependent on the resources available to Police Scotland. The adequacy of resources available to respond and protect the public, is not a matter for this Inquiry but is a matter of concern for Police Scotland, the Police Federation, politicians and of course the public.

[551] The Crown and all the Participants in their submissions offered condolences to the families of John Yuill and Lamara Bell. I recognise the hurt and frustration that they have been caused waiting for this Inquiry to commence. I commend both families for the dignity they showed throughout the proceedings, both in and out of the Court room.

I conclude by offering them the sincere condolences and deepest sympathies of the Court.