South Western Ambulance Service NHS
NHS Foundation Trust



27 May 2014

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Your reference: EA3/DMT File No: 404/20

Dr Elizabeth A Earland
HM Senior Coroner for the County of Devon
Exeter and Greater Devon Coroner's Office
Room 226
Devon County Hall
Topsham Road
EXETER
EX2 4QD

**Private and Confidential**

Dear Dr Earland,

**Roger Clive DUGGAN Deceased –**
**Inquest: 5 March 2014 at County Hall, Topsham Road, Exeter**
**Coroner's Rule 28 Report**

Thank you for your letter regarding the above inquest under Paragraph 7 of Schedule 15 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. Please find the Trust's response below:

**Recommended Action**

Your Regulation 28 Report states that there is a case for examination of the staff response to [redacted] calls on 10 February 2013 and an assessment of whether further training in the evaluation of psychiatric emergencies is required.

**Response**

Following notification of the incident by Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) the Trust conducted an investigation into the ambulance response to [redacted] calls. This investigation was completed in May 2013 and forwarded to NEW Devon CCG for inclusion within the Serious Incident investigation which they led on. A meeting chaired by NEW Devon CCG, and attended by all agencies involved, subsequently took place to discuss the findings of the investigation and develop an action plan. A copy of the investigation report is appended to this letter, unfortunately this Trust was not aware that the inquest into Mr Duggan's death was taking

place as we would have been able to provide you with a copy of that report and details of other actions that have taken place since the incident which would have addressed the concerns raised in the Regulation 28 report.

The investigation concluded that there appeared to be a misunderstanding by the Crisis team on the correct procedure for requesting ambulance transport for patients who required assessment or have a pre-arranged admission which subsequently led to communication difficulties. Following the meeting chaired by NEW Devon CCG, information was disseminated regarding the correct process for arranging transport and would have resulted in an appropriate ambulance response.

In order to provide some context into the role of the Emergency Medical Advisor (EMA) who received the telephone calls from [redacted] I would like to explain the triaging system that the Trust's Clinical Hub uses to categorise incoming calls. The triage system used by the Trust is called '*NHS Pathways*' and all 999 calls to the Trust are triaged using this system.

When a call is received by the Clinical Hub the caller is questioned and the outcome of those questions determines the classification according to the patient's clinical need. This is to ensure that emergency medical help is sent to life-threatening incidents without delay. The system aims to have a clinically robust and consistent, yet compassionate and understanding, approach to telephone triage and it is designed to effectively identify the level of care needed. The system is also able to signpost callers to more appropriate care pathways and therefore more tailored to the caller's requirements.

An alternative pathway includes a wide range of healthcare alternatives that is considered a more appropriate option than conveying a patient directly to Accident and Emergency Departments by ambulance. There are a broad range of professional health care providers who are accessible to members of the public to treat and advise patients, for example GPs, out of hours providers, minor injury units, treatment centres and pharmacies.

The Trust's investigation identified that not all the appropriate *'NHS Pathways'* questions were asked by the EMA and that they should have sought further advice from a Clinical Supervisor within the Clinical Hub. As part of the investigation the EMA completed a reflective practice on their involvement in this case.

Following this incident, in July 2013, the Trust upgraded its version of *'NHS Pathways'* to version 6.5.1 which included a dedicated Mental Health Pathway. This was developed in consultation with specialist Mental Health Teams and allows for patients with mental health symptoms to be dealt with more efficiently with the outcome of the triage (the disposition) being more appropriate. Prior to the implementation of version 6.5.1 all existing Clinical Hub staff were trained in the use of the Mental Health Pathway, this training is also provided for all new Clinical Hub staff as part of their '*NHS Pathways*' training and includes scenarios.

In order to monitor the Trust's response to patients with Mental Health concerns and develop robust policies, procedures and guidelines to improve the quality of care provided, a Mental Health Group has recently been established. This Group is chaired by a Trust Clinical Development Manager and is attended by managers from key areas of the Trust,

including the Clinical Hub. A copy of the draft terms of reference is attached for your information.

I hope the information contained within this letter provides you with assurance that steps have been taken by the Trust, in liaison with the local health community, to learn from this tragic event. If you require any further information, please do not hesitate to contact me.

Yours sincerely,

**Ken Wenman**
**Chief Executive**

Enc: SWASFT Serious Incident Report
Mental Health Group, Draft Terms of Reference