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ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

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[redacted]

13 July 2015

Mrs Louise Hunt
Senior Coroner
Birmingham and Solihull Districts
50 Newton Street
Birmingham
B4 6NE

Dear Mrs Hunt

KINGSLEY BURRELL (DECEASED)

Thank you for your Regulation 28 Report to prevent future deaths, dated 20 May 2015, bringing to my attention the Coroners concerns arising from the inquest into the death of Kingsley Burrell.

The Association of Ambulance Chief Executives (AACE) provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central resource of information about NHS ambulance services. The primary focus of the AACE is the ongoing development of the English ambulance services and the improvement of patient care.

We have given careful consideration to your concerns and have consulted with the mental health leads and senior clinicians in the NHS ambulance trusts.

Taking the concerns in turn, I set out the actions we have taken and response:

1. Medical evidence at the inquest confirmed that Mr Burrell was suffering from acute behavioural disturbance. As a result he continued to struggle against restraint. Patients with this condition are at risk of death through prolonged restraint and struggle against restraint. Most training in relation to restraint deaths focuses on positional asphyxia. Position in this case was not a major consideration. It was clear from the inquest that there was a lack of understanding of how to treat someone with an acute behavioural disturbance. Minimising the period of restraint is key. West Midlands police have undertaken considerable work and training of staff concerning this condition. My concern is that this has not been rolled out nationally and therefore many other forces will not understand the implications of this condition and how best to treat it. I suggest contact is made with Chief Inspector [redacted] at WMP for full information on the changes made in the West Midlands area.

We sent a survey to the mental health leads of NHS ambulance trusts asking if they had a restraint policy and what training and education is currently provided to front line staff around acute behavioural disturbance.

We established that ambulance trusts currently do not have specific policies regarding restraint. Some trusts are currently developing a restraint policy or have wording around restraint in other trust policies such as capacity and consent to treatment. We also established that not all trusts comprehensively incorporate education to their staff around ABD.

The National Ambulance Mental Health Leads group that reports to the National Ambulance Service Medical Director group (NASMeD) have been asked to develop the principles and

recommend what should be part of policies around conveyance of mental health patients, highlighting the principles of restraint and awareness of acute behavioural disturbance. This will include an awareness of the impact that prolonged restraint can have on an individual and the importance of performing physical observations during and after physical intervention/restraining. Also the importance of documenting that any physical intervention has been used on a person. This group will then share these principles with ambulance trusts for them to consider implementation. This action will be completed by November 2015.

We have made a recommendation to the National Education Network for Ambulance Services leads (NENAS) that each trust considers including, if not completed already, the education of front line staff and control room staff in acute behavioural disturbance to raise awareness of the condition and how it can present in a patient.

We have approached the leads of the two systems used in ambulance control rooms that triage 999 calls and asked them to review their triage pathways to ensure that ABD is included or referred to in the questions that are asked (AMPDS and NHS pathways).

An ambulance guideline development group is currently working on revising the UK ambulance services clinical practice guidance around the management of mental health patients. This will include aspects of restraint and include recognition and management of patients with ABD. This work will be completed in 2016 and will be incorporated into the guidance used to inform the clinical practice of ambulance clinicians across the UK.

Ambulance clinicians are legally authorised and obliged under the Mental Capacity Act to act in the best interests of, and provide treatment for, patients who lack capacity, even where the patient refuses treatment or are abusive, threatening or violent.

The Mental Capacity Act also supports the use of reasonable force to ensure that patients lacking capacity receive care that is in their best interests or are protected from further harm. However ambulance clinicians are neither trained nor expected to restrain patients who are acting in a threatening or violent manner. Ambulance staff are trained to provide minimal restraint and use soft control technique/physical intervention in cases where patients lack capacity and there is no perceived risk of harm to them or the patient. In the event of restraint being required for a violent patient ambulance staff will continue to rely on the Police to provide that restraint as their officers have been specifically trained to do so. In these instances ambulance staff are required to monitor the patient to ensure their continued safety.

2. The West Midlands area now have a crisis team that works with people who are in a mental health crisis. This involves a mental health worker and ambulance crew working together with the police to try to help patients with acute mental health disorders. My concern is that this is not a national system. Chief Inspector [redacted] at West Midlands Police can provide full details of the scheme.

3. This case has resulted in a multi-agency review of how patients are managed between the services when crisis occurs. A new conveying of patients policy has been devised. Critically police now only attend a mental health ward if there was a patient who is threatening staff or if there is disorder on the ward. My concern is that this is not reflected nationally. Chief Inspector [redacted] at West Midlands police can provide full details of the policy.

In the survey we sent to trusts, we asked what schemes were in existence around multi agency working. We found that there were a variety of schemes, some in pilot stage and still being reviewed in terms of effectiveness and efficiency, others in planning. Some of them had paramedics working as part of a joint team, others had pathways where paramedics could refer to mental health teams.

Due to a now recognised national shortage of paramedics, being able to provide a paramedic to specifically work as part of a team to respond to patients with acute mental health disorders will be difficult for some trusts, and will depend on local commissioning arrangements. We recognise that these schemes are likely to continue to develop.

Ambulance trusts do work closely with their local Police Forces, and we found that most trusts have at least three police forces within their region. Therefore it is important to ensure that collaborative arrangements are in place to jointly manage a range of incidents including the multi-agency response to patients experiencing mental health crisis.

At a national level the AACE and the National Police Chiefs Council (NPCC) have been working closely together to improve arrangements for inter-agency working and the demand that ambulance trusts and police forces generate for one another; the aim being to improve the response to the public whilst also operating together as efficiently as possible. Particular efforts have been expended in relation to offering better care to patients experiencing mental health crisis and the Crisis Care Concordat, supported by local declarations, have given added impetus to this work.

As a consequence ambulance trusts in England introduced new protocols in April 2014 designed to improve the speed of response to patients detained under Section 136 of the Mental Health Act in order to offer a clinical assessment more quickly and to arrange subsequent conveyance to a place of safety more efficiently. Data for 2014/15 indicates that there have been encouraging improvements with 74% of incidents where the police requested an ambulance receiving a response within 30 minutes. AACE continue to work with the NPCC, Home Office and the Department of Health to drive further improvements in both the speed of ambulance response and the proportion of patients conveyed by ambulance rather than police vehicles. In the respect of the latter recent Home Office data indicates that for Section 136 where patients were conveyed by the Police 43% of cases were due to risk or behavioural issues and in 32% of cases no ambulance had been requested by the police. AACE continue to work with the NPCC to ensure that an ambulance is always requested and that police conveyance is reduced to as low a rate as possible.

The College of Policing, Health and Ambulance Service representatives are currently working together to devise a national protocol for the management of ABD in the pre-hospital setting. This is a complex piece of work but the impetus certainly exists to ensure a suitable outcome is reached that will be both manageable and of course beneficial to the patients concerned.

I hope that you will agree that we have dealt comprehensively with the concerns that you have raised. We will continue to ensure co-ordination between ambulance trusts who have shown themselves to be absolutely committed to learning from this tragic event and do everything within our power to prevent it happening again in the future.

Yours sincerely

A. C. Marsh.

Anthony C Marsh QAM SBStJ DSci (Hon) MBA MSc FASI
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