East Midlands
Ambulance Service
NHS Trust

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CONFIDENTIAL

Our Ref RH/NH/Vout

6 February 2018

Mr A McNamara
HM Assistant Coroner
Office and Main Court
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mr McNamara

Re: Report to Prevent Future Deaths: Mr Ryan James Vout (deceased)

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 6 November 2017 (received on 18 December 2017), bringing to my attention HM Coroner's concerns arising from the Inquest into the death of Mr Ryan James Vout.

I would like to assure you that within the East Midlands Ambulance Service (EMAS) all matters related to patient safety are taken extremely seriously. In particular, matters arising from Coroners' Inquests from which lessons can be learnt, including Prevention of Future Death Reports, are discussed within the Incident Review Group and Lessons Learned Group.

This process has been applied to the Prevention of Future Death Report pertaining to the Inquest into the death of Mr Ryan James Vout.

The **MATTER OF CONCERN** specific to EMAS is as follows:

- **The inability to pre-arrange attendance of an ambulance when police officers exercise a s.135 (1) MHA Act 1983 warrant**

  All interested parties, especially the police, expressed frustration that within Nottinghamshire there is no alternative, dedicated, fully equipped ambulance, capable of being pre-booked for attendances such as the one in this case for the execution of s135 MHA 1983 warrants (or detention under s136 MHA 1983).

I set out below the actions that EMAS proposes to take and our response to HM Coroner's concerns as detailed in the PFD notice.

EMAS acknowledges its responsibility to enact a duty of care to all patients.

The ability to pre-book an ambulance to attend an incident with a police officer or approved mental health practitioner (AMHP) to exercise a Section 135 or Section 136 warrant under the 1983 Mental Health Act has always been available. The conflicting priorities of operational demand often require EMAS to prioritise patients according to the presenting complaint. Therefore clinical presentations often take precedence and need a more urgent response.

As there are conflicting challenges around response times, EMAS recognises the importance of ensuring that patients presenting with acute psychotic disorders also get an urgent response. The Trust plan is to adapt its operating model with an urgent care tier, which will enable patients with a more urgent care requirement, to be responded to appropriately and safely in a timely manner. This will go live across all five counties on 2 April 2018 and should allow us to better meet the needs of our patients with mental health disorders.

We continue to work collaboratively with our mental health providers and stakeholders to improve our services for patients with mental health problems.

I hope that the measures set out in this letter provides you with the appropriate level of assurance in relation to EMAS' commitment to continuous improvement in the management of mental health issues.

Please do not hesitate to contact me should you require any additional information, or any clarification, in connection with the above.

Yours sincerely

Richard Henderson
Chief Executive