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Rachael Clare Griffin
H M Senior Coroner for Dorset

Dear Ms Griffin

REGULATION 28 REPORT – ACTION TO PREVENT FUTURE DEATHS: DOUGLAS PAUL OAK

We are writing in response to the Regulation 28 report to prevent future deaths following the inquest into the death of Douglas Oak which you issued on 24th October 2019 to Martin Flaherty on behalf of the National Ambulance Service Medical Directors (NASMeD) and Anthony Marsh, Chair of the Association of Ambulance Chief Executives (AACE). We would like to clarify that [redacted] is the Managing Director of AACE and in relation to this report we have liaised with [redacted] who is the Chair of NASMeD.

AACE is a formally constituted private company wholly owned by the English Ambulance NHS Trusts who are all full voting members. Its primary focus is the ongoing development of the English ambulance services and the improvement of patient care. It is a company owned by NHS organisations and it wholly owns the intellectual property rights of the JRCALC UK ambulance service clinical practice guidelines. NASMeD is a subgroup of AACE.

You requested that the NASMeD and AACE consider matters of concern and suggested that action is taken to prevent future deaths. We will address each of your concerns, insofar as we are able.

i) NASMeD, and the Association of Ambulance Chief Executives (AACE) as its parent body, have no involvement in the development of the content of First Aid manuals and are therefore unable to assist with this matter.

ii) Joint guidance between the statutory ambulance services and the Police Forces is in development, overseen by a joint committee of AACE and the National Ambulance Commissioning Network, and supported by the ambulance and mental health group in NHS England. NASMeD has requested development of ambulance guidelines by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and these are due to be ratified shortly. The guidelines have been developed following consultation with the Faculty of Forensic and Legal Medicine (FFLM) and the Faculty of Pre-Hospital Care (FPHC).

    The provision of chemical sedation by all paramedics is a matter of contention, and one which we have previously discussed on more than one occasion with [redacted] including in national conference with the Police in December 2018. Chemical sedation for any indication and, perhaps more importantly, the skills to manage a chemically sedated patient falls outside the scope of practice of frontline ambulance paramedics. In addition, the infrequency with which they would need to practise these skills would lead to skill fade and poses a risk to patient safety.

    Dr Mark does not agree with [redacted] position that "chemical sedation or tranquillisation is often the best way to calm a person suffering with ABD". A two-year audit by London Ambulance Service NHS Trust, the results of which are known to Dr Yong, demonstrated

that 62% of patients with suspected ABD, attended by Advanced Paramedics who were trained in chemical sedation, were successfully managed using only verbal de-escalation techniques.

Work is ongoing, between Yorkshire Ambulance Service NHS Trust and the four Yorkshire and Humber Police Forces on behalf of the national groups described above, to establish the most appropriate response categorisation for patients with suspected ABD. The first component of this study is due to conclude in March 2020 and will report shortly afterwards. The framework for the study was devised following consultation with all English Police Forces.

The primary goal in the prehospital management of patients with suspected ABD is rapid transfer to an Emergency Department for further assessment and intervention as indicated therefrom. It may be that on an individual case by case basis, in consultation with Police and Ambulance control rooms, the most appropriate management for a patient with ABD is transfer by the Police to an Emergency Department. The study described above is exploring this and other options.

iii) Following the publication of the JRCALC guideline on ABD there will be an expectation that all statutory ambulance services will ensure that their frontline staff are aware of, and cognisant with, its contents and ambulance control staff are also made aware of the new guidance.

Following the outcome of the study described above recommendations will be made to the NHS England lead group which oversees emergency call prioritisation to incorporate specific response categorisation for patients with suspected ABD.

iv) Annual refresher training in ABD is disproportionate given the incidence of these cases and the need to maintain and develop the broad range of competencies required of a frontline paramedic in a statutory ambulance service. We believe each of the English ambulance services receives two or three calls each week for patients with suspected ABD, amongst two to four thousand 999 calls per day. Whilst NASMeD or AACE is not in a position to mandate training requirements, we would not support a recommendation for annual refresher training on this subject.

v) We do not believe that the absence of common terminology or the use of the term 'on the hurry up' was the issue. The ambulance response to all incidents are prioritised on information based on the patients presenting condition. Therefore it is essential to obtain appropriate information about the patient's condition, and that this is passed from police to ambulance services in order to correctly prioritise the response and this will be our principal focus of ongoing work with the police Once the new guidance on ABD has been ratified and issued and the trial in Yorkshire as described in point ii above has been completed, we will continue to discuss this in our work with the police to improve communications between ambulance and police control rooms.

vi) On the subject of cross working with emergency services, whilst we understand the motivation behind the evidence given, in practice, where ambulance trusts have placed clinicians in Police control rooms, it has not proven to be an efficient operating model. Improving communications and operating practices appears to be at the heart of this recommendation and we feel this would be best addressed through the arrangements to improve the joint working between police and ambulance services. As described in point v) above we would propose to develop this in close partnership with the police.

vii) The provision of training for control room staff in ambulance services will be considered following recommendations that arise from the response categorisation study described in point ii above.

viii) We welcome the development of clinical governance partnerships between Emergency Services, rather than Police Clinical Governance Boards that operate independently of the ambulance service. The development of partnerships would assist in addressing the interoperability issues you have highlighted in your report.

ix) AACE agree with the evidence offered by [redacted] that a direct call from the Police Officer on scene to the ambulance control room (either through dialling 999 or use of Airwave radio) is likely to result in more accurate triage of the patient's condition and better assessment of the appropriate response priority. AACE have previously shared this view with the National Police Chiefs Council (NPCC) and with the multi-agency Emergency Services Demand Management Group (ESDMG) chaired by the Home Office.

AACE understand the cultural and practical barriers raised by the NPCC and accept that direct communication from the Police Officer on scene may not always be practicable. Ambulance trusts have locally agreed arrangements for the passage of information between Police and Ambulance control rooms. This is best determined at a local level due to differing technologies and working practices.

For example, in London the Police and Ambulance Computer Aided Dispatch (CAD) technologies are linked enabling direct passage of information with no voice contact by phone. In some ambulance services, requests from Police control rooms are directed through the 999 system and in others there is a dedicated phone number for contact between Police and Ambulance control rooms.

Where an ambulance trust has agreed arrangements with the Police for a dedicated phone line for the passage of emergency requests for ambulance attendance it would seem important to ensure that the speed with which the phone is answered is in line with 999 call answering. AACE will share this, and the other operational considerations outlined in this report, with the National Directors of Operations Group (NDOG) for ambulance services.

x) Prior to your report, the subject of the recognition and management of ABD in the prehospital environment had already received considerable attention and work has been progressing to address this complex topic, as described above. South West Ambulance Service NHS Foundation Trust have been appraised of this work through NASMeD. Our work nationally will continue to progress in this important area as soon as practicable, as described in the other points within this report.

xi) This report and our ongoing work will be discussed and shared at future meetings of NASMeD, NDOG and with the Ambulance Chief Executives Group.

I hope that you will agree that we have responded to the concerns that you have raised and explained our reasoning. We can assure you that we are absolutely committed to learning from all such adverse events and doing everything within our power to prevent them happening again in the future.

If we may be of further assistance, please do not hesitate to contact us.

We would like to extend our sincere condolences to the family of Mr Oak.

Yours sincerely

Martin Flaherty OBE
Managing Director