NHS
South Western
Ambulance Service
NHS Foundation Trust

Our ref: WW60.as

9 October 2020

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Private & Confidential
HM Coroner David Ridley
Senior Coroner for Wiltshire & Swindon

By email only: WSCoronersOffice@wiltshire.gov.uk

Dear Mr Ridley

Prevention for Future Death report touching on the deaths of Mrs Mary Johnson and Ms Vhari Ingall.

I write in connection with your inquiries touching on the deaths of Mrs Mary Johnson and Ms Vhari Ingall, and in response to the Prevention for Future Deaths Report issued to South Western Ambulance Service Foundation Trust on 1st April 2020. You will be aware that the report was marked for the attention of my predecessor- Mr [redacted]; please note that I have since assumed the role of Chief Executive Officer and accordingly have sought to address the concerns you raise below.

I was extremely saddened to hear of both Mrs Johnson and Ms Ingall's deaths and understand that the circumstances of these deaths would have been extremely difficult for both families. I would therefore like to take this opportunity to offer my sincere condolences to the families of both Mrs Johnson and Ms Ingall and to reassure you that both cases have been taken extremely seriously, with a significant amount of work undertaken to ensure any learning identified is embedded within the organisation.

Whilst I am aware that the events leading to their respective deaths were somewhat different, HM Coroner has, within the report drawn parallels between the two incidents, identifying two chief concerns:

- Do Not Resuscitate (DNAR) Forms only apply in circumstances where patients will have a 'natural' death and would therefore not be applicable in circumstances where a patient has self-harmed as this could in no way be considered a 'natural' death and
- The requirement for paramedics to make decisions regarding the resuscitation of patients who have self-harmed and who are in possession of documents that purport to support their actions.

In order to address the concerns, I would advise that both patient deaths have been investigated separately by way of Review, Learn and Improve investigations (formerly known as Serious Incident investigations) and comprehensive reports compiled, both of which will be shared with the respective families and will be provided to HM Coroner separately.

Although distinct from one another, the investigations have run concurrently and have sought to address a myriad of complex issues, ranging from:

- Capacity assessment in intoxicated patients, how this is assessed and the factors to be considered;

- Consent to treatment in circumstances where a patient has refused treatment and is assessed as having capacity;
- Best-interest decision making and the weight to be apportioned to each factor considered;
- The validity and applicability of documentation including DNARs and advanced decision documentation in circumstances where a patient has self-harmed;
- The extent to which paramedics should exercise professional curiosity;
- Availability and accessibility of available guidance for paramedic crews;
- The extent to which paramedics are able to access expert mental health and senior clinical support externally.

One of the similarities between the two cases is that Mrs Johnson and Ms Ingall both had DNAR forms in addition to other documentation including advance decisions or a TEP (Treatment Escalation Plan) and notes expressing a wish to end their lives.

A DNAR form is not a legally binding document and as HM Coroner has identified, would not be applicable in circumstances where a patient has self-harmed, as this would not achieve a naturally occurring death. Conversely, an advanced decision (or ADRT (advanced decision to refuse treatment)) may be applicable if specific to the set of circumstances, is valid and there is no reason to doubt the patient's capacity at the time of writing.

In the case of Mrs Johnson, the investigation revealed that the paramedic who attended her was aware that the DNAR documentation was not applicable but was nevertheless keen to ensure Mrs Johnson's wishes were factored into the decision making, as expressed by her actions in taking an apparent overdose and within the documentation provided, which included a note detailing her expressed wish to end her life. The paramedic sought advice from the Senior Clinical Advisor on-call (ambulance senior clinician) on this point and having consulted with Mrs Johnson's family at length, made a 'best interests' decision to leave Mrs Johnson with her family- that is a decision that incorporates all known variables with a view to making what was perceived to be the right and best decision for the patient.

In Ms Ingall's case, the investigation showed that the paramedic crew spent a vast amount of time with her on scene, endeavouring to persuade her to go to hospital to receive treatment following an overdose of medication. Similarly, Ms Ingall had both a DNAR and a TEP in her possession, neither of which applied. By contrast, although it was acknowledged by the crew that Ms Ingall was intoxicated, they did not consider the level of impairment to be so great that it impacted on her capacity to make decisions, however unwise they might have been. The crew recall repeatedly assessing Ms Ingall's capacity throughout their time with her and report that she was able to converse with them freely and demonstrated a clear understanding of the consequences of her actions, explaining that she was aware that she would die without treatment.

The crew report that Ms Ingall had capacity up until she rapidly deteriorated and went into respiratory arrest and made considerable attempts to seek external support via mental health and out of hours' services. Ultimately, although the crew mistakenly considered the documentation to be applicable, their decision to allow Ms Ingall to die was predominantly based on their repeated assessment of her having the capacity to make her own decisions and the demonstration of her understanding of the consequences. They therefore did not consider it appropriate or in the patient's best interests to treat and resuscitate.

Given the complexity of both cases and the plethora of issues explored, the investigating team reviewed the guidance available to crews with a view to establishing both the accessibility and level of clarity provided for the management of patients who have self-harmed and refuse

treatment. They found that whilst there is a wealth of national and internal guidance available, in situations such as those described above, where paramedics are faced with a multitude of issues, the relevant guidance is often contained within multiple sources, necessitating a need to read various texts in conjunction with one another to enable them to formulate a plan.

Therefore, in addition to a clear requirement to reinforce education around the legality and applicability of documentation such as DNARs and ADRTs, in circumstances where a timely response is imperative, proactive steps have been taken by SWASFT to ensure a greater understanding of these issues and to embed the learning taken from these incidents with a view to improving the quality of the service provided to our patients and their families.

In terms of the action taken by SWASFT, it was recognised that immediate action was required to ensure staff understood their legal obligations and could distinguish between the varying documents they might encounter, including DNARs, Advance decisions and a Lasting Power of Attorney (LPAs). Accordingly, as an interim measure, a Clinical Notice was issued to all staff on 22nd May 2020, a copy of which is enclosed for your ease of reference.

It was, however, acknowledged that a more robust review of guidance was required, with a view to developing a more focused guideline identifying the key steps to be considered by crews, in addition to some detailed explanatory text identifying the legislation that underpins it. There ensued a process of collating the relevant information from various sources and incorporating it all into one accessible and easy to comprehend document. A guideline entitled 'Mental Health and capacity considerations in patients who present as having self-harmed or attempted suicide' has now been developed by the team, incorporating references to JRCALC (Joint Royal Colleges Ambulance Liaison Committee), NICE and internal SWASFT guidance. Given the complexity of the task, specialist legal input was sought in addition to the clinical expertise of a mental health expert who has provided some valuable insight into the management of patients who have self-harmed. One area HM Coroner may wish to explore further relates to the applicability of ADRTs in circumstances where the patient has self-harmed and refuses treatment. It is understood that provided the ADRT is valid, clearly provides for the specific set of circumstances in which the patient presents, and there is no reason to suspect the patient did not have capacity at the time of writing, the ADRT would be legally binding. The concern here is in relation to the capacity of the patient at the time the document was drafted, given this may not have been formally assessed and so may be questionable if in a state of suicidal crisis for example. Although the guideline attempts to address this matter, it is arguable that the law may need to be clarified around this point.

The Trust will implement the new guideline on 14th October and will notify staff of this together with a briefing of the subject matter via the Chief Executive's bulletin the same day. Members of the Quality and Clinical Care directorate will then work alongside the Learning and Development team to design training materials to be delivered to staff as part of the 2021/22 staff training package. Given the complexity of the subject matter, it will be important that the content is carefully considered and planned so as to ensure effective delivery to the workforce. Completion of the training is mandatory with the obvious exceptions made for those on maternity and sick leave. In previous years the Trust has routinely achieved 90-95% of the workforce trained with a firm plan to ensure that 100% of the workforce has received their education by the end of quarter 1 the following year. A copy of the guideline has been enclosed for information and the Trust will also share the new guidance with the Association of Ambulance Chief Executives and CQC in due course.

In terms of other actions taken, although the formulation of a new guideline was a key recommendation made for both RLI investigations, other actions included working closely with local mental health trusts and out of hours' services to strengthen communication links and the support provided to paramedic crews managing mental health patients. In addition, although it is clear from

the investigations undertaken that the crew members did their very best for both patients, individual learning was identified and I understand all those involved have thoroughly reflected on the incidents and engaged extremely well in the investigation process.

The Trust has also recognised the need to recruit a substantive Senior Mental Health Practitioner to provide ongoing advice and support to staff and to develop services sensitive to the needs of people with mental health issues or a learning disability. This role will provide strategic leadership ensuring mental health remains a key priority for the organisation. They will work with stakeholders to develop pathways of care and services for patients as well develop guidance and training for staff. One key work stream will be to discuss with commissioners the potential recruitment of mental health practitioners within the ambulance clinical hubs to provide immediate advice to crews.

In conclusion, I hope both the families of Mrs Johnson and Ms Ingall, and HM Coroner will be assured by the decisive steps taken by the Trust to address the concerns raised and furthermore by the considerable amount of work undertaken to implement improvements to the service the Trust provides to our patients and their families.

Yours sincerely

[redacted]

Chief Executive Officer

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