Our services:
Emergency and urgent care
Non-emergency patient transport
NHS 111

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NHS Trust

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Office of HM Coroner
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29 August 2017

Dear Ms Robertson

REGULATION 28 REPORT – DAVID MICHAEL LEE

I write further to your letter dated 28 June 2017 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching upon the death of David Michael Lee, which took place on 21 June 2017.

I hope to be able to address your concerns, as set out in Section 5 of the Regulation 28 Report, namely:

> *That the call was inappropriately terminated and that this may continue in the future. That there was a missed opportunity to escalate the urgency of the requirement for medical assistance due to the call being terminated. Since the call guidance has not been circulated to members of call handling staff regarding in what circumstances it is appropriate to terminate call and when a call handler should, as a matter of best practice, remain on the line with the patient. Such guidance was circulated twice prior to the deceased's death but was not adhered to on this occasion. That there has been no training given to staff since the deceased's death to address when it is appropriate to terminate calls with patients.*

I am advised that on 18 February 2017 at 06:00, NWAS received an emergency call to attend [redacted] The call came from Mr Lee himself and he told the call handler that he had taken an overdose of 200 Nytol tablets approximately 25 minutes previously. The call handler established that Mr Lee was 45 years old and that this was an intentional overdose. In answer to the call handler's questions, Mr Lee said that he was not violent and he did not have a weapon. It was also established that Mr Lee was completely alert but was not breathing normally. Mr Lee described his breathing as '...just starting to slow down'. The call was coded as a Green 2 response, which in line with the Medical Priority Dispatch System (MPDS) requires a face to face response as soon as practicable.

The NWAS call handler stayed on the line with Mr Lee and he told her that he had suffered from depression and this had become worse recently. During the call, Mr Lee said that he felt drowsy and felt that he could not breathe properly. At 06:30, the call taker told Mr Lee that she needed to hang up to take another call and that help had been arranged. She also advised Mr Lee to call back if anything changed.

At 07:13, emergency ambulance call sign A424 was allocated to Mr Lee and arrived on scene at 07:23. On arrival, the crew from A424 called the Emergency Operation Centre (EOC) to advise that the door to the property was open but that there was a dog present and they were therefore unable to go inside. The resource dispatcher called Mr Lee's telephone number back but there was no reply.

At 07:31, A424 called EOC again to advise that they had entered the property and found Mr Lee in cardiac arrest and asked for a backup vehicle. Rapid Response Vehicle (RRV) R423 was allocated immediately. A further RRV, R459, was also allocated at 07:32. R423 called EOC to advise that Mr Lee was deceased and to request Police attendance.

I am advised that at the inquest, EOC Deputy Sector Manager Angela Lee gave evidence to the Coroner that the emergency call had been audited and it had been established that it had been processed correctly based on the information given to the call taker and the correct response code was obtained. The call taker stayed on the line with Mr Lee for 30 minutes, however due to Mr Lee telling the call taker that he was starting to feel drowsy, the call taker should have stayed on the line with him until the emergency ambulance arrived. Ms Lee confirmed in evidence that this was an individual error and that the call taker has undertaken a reflective learning exercise in order to identify the error made and reflect on her practice for the future.

Ms Lee advised the Coroner in evidence that the Trust issue guidance '*CDE-NW0025 - Staying On The Line*' to all call takers as to the circumstances in which a 999 call can be terminated prior to attendance of a clinician. Ms Lee confirmed that this guidance is circulated periodically as there is a balancing act to be sought in ensuring that call takers are not overly cautious with regards when a call can be terminated, thus resulting in them staying on the line with callers for longer than is necessary and preventing them from being released to answer further emergency calls. Ms Lee confirmed that the guidance had not been circulated since this incident, but had been circulated prior, and reassured the Coroner that this would be recirculated following the conclusion of the inquest to reinforce the practice of when emergency calls can realistically be terminated.

Following the inquest the Trust have revised the relevant guidance in respect of incidents where call takers should remain on the line and have circulated this to all EOC Supervisors, with the following key points emphasized as direct learning from this case:

- *First party callers who are not alert cannot be disconnected after 10 minutes. The call takers should remain on the line.*
- *Second party callers can only be disconnected where there are no changes to the patient's condition AND there are no breathing problems at all.*

EOC Supervisors have subsequently conducted one to one briefings with all call takers in all three EOC's to discuss the guidance and ensure that the practice of terminating calls is fully understood. All call takers are required to provide their signature to confirm that they have read and understood the guidance and its use.

A copy of the revised Guidance '*CDE-NW0025 - Staying On The Line*' is attached to this letter for you.

To ensure that the guidance is re-circulated to all call takers at appropriate periodic intervals, the Trust's Operations Director has also put in place a system whereby he will be periodically reminded to request that the EOC Management team complete the above recirculation process, thus ensuring all call takers are regularly reminded of the practices regarding call termination.

To ensure further Trust wide learning, the Trust's Legal Department are to produce a case study based on this incident and the appropriate use of call terminations, which will be used in scheduled training sessions/workshops across all EOC's for new and existing call takers; again to reinforce the practices that should be followed in situations such as this.

I am very sorry that you had cause to issue this Regulation 28 Report and I would like to take this opportunity to emphasise that I do take your concerns very seriously. I hope that I have responded to your concerns and reassured you of the work that the Trust has undertaken to ensure that similar incidents are avoided in the future.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me.

Yours sincerely

DEREK CARTWRIGHT
Chief Executive Officer