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Mr. David Ridley
HM Senior Coroner
Wiltshire & Swindon Coroner's Office
26 Endless Street
Salisbury
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21 July 2020

Care Quality Commission
Our Reference: MRR1-8774360992

Dear Mr. Ridley,

Regulation 28 report to prevent future deaths following the cases of Mary Grace Johnson and Vhari Ingall

Following the commencement of your investigation into the deaths of Mrs. Johnson and Ms. Ingall, the Care Quality Commission (the 'CQC') received a copy of the Regulation 28 report because you felt that the commission has the power to take action.

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. CQC sets out what good and outstanding care looks like and work to make sure services meet fundamental standards below which care must never fall.

Background

South Western Ambulance Service Foundation Trust (SWASFT) is registered with the CQC to provide the regulated activities of:

- Diagnostic and Screening Procedures
- Surgical Procedures
- Transport Services, triage and medical advice provided remotely
- Treatment of Disease, Disorder or Injury

The trust provides these services from a range of bases in the Southwest of England with its headquarters based in Exeter. The service provided by SWASFT covers a geographical area of one fifth of England's land mass.

The most recent inspection report for SWASFT was published in September 2018, where the organisation was rated "Good" overall.

The CQC became aware of the deaths of Mrs. Johnson and Ms. Ingall on 22 April 2020 upon receipt of the first regulation 28 report. At this time, SWASFT were contacted by the CQC to ask for the investigation reports into the deaths of the two patients. SWASFT began this investigation upon the receipt of the Regulation 28 report, and so at this time were able to send only the 72-hour investigation reports. Subsequent to the receipt of the amended Regulation 28 report, where the CQC were named as responders, further information was requested from SWASFT to enable a closer analysis both of the patients identified, but also

the processes and guidelines that supported front line staff in the treatment of all patients in similar circumstances.

Matters of Concern:

(1) Frontline workers are taking decisions regarding non-resuscitation of individuals with a "Do Not Resuscitate" (DNR) order in place, where it seems apparent that the individual has – or has attempted to – take his or her own life. A DNR document applies to allow specifically a natural death.

Immediate Concerns

Upon receipt of the regulation 28 report from the coroner and subsequent review processes, SWASFT were asked to provide assurance that actions had been taken to mitigate the immediate risk of a similar occurrence. The CQC were provided with this in the required timescale, along with information about how the receipt and understanding of this information was governed. This provided the CQC with a level of assurance that with immediate affect, the risk of a similar occurrence is mitigated as far as is practicable.

Ongoing Management of risk

In addition to information about the management of immediate risk, the CQC asked SWASFT to review all cases of apparent suicide attended by their crews in the preceding 18 months where resuscitation had not been attempted. This review was conducted using a comprehensive review of systems used to capture information about patients and the treatment received. This demonstrated that in such cases, the decision not to resuscitate was legitimate in that these patients were past the point that resuscitation could have saved their lives – and were in accordance with the guidance provided by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

The CQC asked SWASFT for information that demonstrated an ongoing management plan of the situation so that it could be assured of the sustainability of such mitigations as described above. Information included within a letter sent to us on 10th June 2020 provided assurance of a comprehensive plan surrounding the development of a clearer process and policy for staff to follow, and training to sit alongside this subject. SWASFT stated that the plan would be for this to have been completed by all staff by March 2021. It is fair to say that we have confidence in their ability to deliver the action plan as described, based on our knowledge and experience of the organisation. In putting together this plan, it is our understanding that SWASFT have worked with legal support to ensure that the information included in the new policy is not only clear and easier to access but is also legally accurate.

With regards to the plans as outlined above, review of the achievement of this will form part of the CQC's ongoing engagement with SWASFT as well as being followed up directly with front-line staff and leaders at the next inspection. SWASFT were scheduled to have an inspection during the spring of 2020. However, due to the coronavirus pandemic, all routine inspections were cancelled. At the time of writing, it is not yet known when these will resume but it is not envisaged to be imminent. That being said, should a risk present that requires a closer examination through the use of an inspection, then one will be carried out. SWASFT's cooperation and readiness to mobilise a solution to the concerns outlined in the regulation 28 report does not

suggest a need to inspect at this time. However, should further information alter that viewpoint when the investigations are completed, the situation and decision to inspect will be reassessed.

(2) The belief of the coroner, that this may be a wider issue, nationally and not limited to the South Western Ambulance Service Foundation Trust (SWASFT)

Information surrounding the cases of these two patients, and the subsequent actions taken and information gained by CQC, has been shared with the national ambulance group that sits within the CQC. This means that the findings surrounding the deaths of these patients can be used to enhance engagement with, and ongoing inspections of, ambulance trusts across the country.

As part of our inspection methodology, we routinely look at the training in, and presence and understanding of processes and policies surrounding the mental capacity act and best interest decisions. This is ordinarily a more generic look at such subjects, and so the addition of this focus on patients who have apparently attempted to take their own lives will be promoted within the CQC by the ambulance group.

Having reviewed the inspection reports of a number of ambulance trusts across the country, there is no evidence that as part of those inspections the CQC has specifically asked about the affect of apparent suicide in the presence of an DNR document. Through the channels of communication open to the ambulance group this question can be promoted to colleagues carrying out inspections of these trusts in the future.

Hopefully, this letter provides you with sufficient information about the concerns raised in the regulation 28 report surrounding the deaths of Mrs. Johnson and Ms. Ingall, together with our ongoing regulatory approach to the matter.

Should you require any further information, please contact [redacted] (Inspection Manager) by phone on 03000 [redacted], or via e mail at [redacted]@cqc.org.uk

Yours Sincerely

[redacted]

[redacted]
Head of Hospital Inspection