NHS
South East Coast
Ambulance Service
NHS Foundation Trust

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Mrs V. Hamilton-Deeley
HM Senior Coroner for Brighton and Hove

By email only

12 April 2021

Dear Madam

The late Ms Lisa Codling

I write by way of SECAmb's response to the Regulation 28 Prevention of Future Deaths report issued in this matter on 19 February 2021.

I was very sorry to hear of Ms Codling's passing and I would like to pass my personal condolences to her family and friends. Please be assured of our commitment to undertake critical self-reflection that seeks to improve the service we offer and to support patients like Ms Codling.

Your report which you address to me was also addressed to my Medical Director and her Deputy and Assistant. I write this response on behalf of all parties, after collaborating with them in the investigation of the matters raised in your report.

History of the incident

I thought it may be helpful for others reading this response, who did not have the benefit of attending the inquest, if I set out a brief history of the events of 5 September 2020. I have summarised and limited details around Ms Codling's personal circumstances in the interest of sensitivity:

19:30 SECAmb received a call from Ms Codling's partner. He was outside her house and was concerned that he had seen her take [redacted] paracetamol tablets, with the possibility that she had taken more. He thought that she was suffering a psychotic episode, following an upsetting conversation with him about family matters. The call reached a Category 3 disposition; the call taker called back Ms Codling first-hand, who denied taking an overdose or having any mental

health issues. Notwithstanding this, the call taker decided to pass the matter to an appropriate registered clinician for further assessment.

20:08 A specialist Mental Health Nurse within SECAmb's Emergency Operations Centre called Ms Codling. Again, during this call Ms Codling denied having taken an overdose, having any suicidal ideation or having a mental health crisis, despite much careful probing by the clinician. Although Ms Codling denied a need for medical assistance, the clinician persuaded and successfully sought consent for her to agree to an ambulance attending to check her over.

20:20 The call with the clinician ended and the call was placed into the queue for a Category 3 ambulance, with a target to respond within two hours of the initial call.

21:53 An ambulance was assigned to Ms Codling but was redirected shortly thereafter to attend a higher priority call.

22:20 A welfare call was made by SECAmb to Ms Codling's partner. He informed the caller that he had received a text from Ms Codling which read "It's too late".

22:33 Another ambulance was assigned to attend Ms Codling.

22:40 The ambulance arrived at Ms Codling's address and she was found in cardiac arrest. Attempts to resuscitate her were unsuccessful.

Investigation of the incident

An investigation was carried out into this incident by our Head of Integrated Governance for 111 and 999, [redacted] and one of our Operations Managers with responsibility for clinicians in our Emergency Operations Centre, [redacted] Their report was submitted to the Court prior to the inquest and a copy is appended to this letter. The key findings were:

- The Trust had implemented (from 1 May 2020) a process that exceeded NHS Pathways' current requirements by referring intentional/unintentional overdose calls to a clinician; that new process was correctly followed.
- The Mental Health Clinician successfully negotiated with Ms Codling, who denied taking an overdose, to have an ambulance attend; without such professional negotiation it is apparent that Ms Codling, who evidently presented as possessing Mental Capacity, would have chosen to have no response.
- At all stages SECAmb preferred the information from Ms Codling's partner and acted accordingly and in her best interest.
- Ms Codling's partner stated that he had seen her take [redacted] paracetamol tablets. This was the baseline information which would not have been a toxic overdose based on the average size of an adult female, and this was confirmed by post mortem findings.
- In all senses SECAmb did treat this as an important issue and recognise that the patient needed to be seen and ultimately conveyed to hospital by an ambulance crew (unless she was deemed to have capacity and refused).

- ❖ When the Mr Codling's post mortem and toxicology reports were received, a further detailed review of the case was undertaken

The email referred to in the Regulation 28 report

The Regulation 28 report refers to an email sent by [redacted] to yourself on 12 October 2020. [redacted] is SECAmb's Head of Legal Services and provides pre-inquest information to the court in order to assist the Coroner's enquiries. Upon enquiry as to why the incident had not been declared a Serious Incident (SI), [redacted] provided the reasons that the Serious Incident group did not declare the incident as an SI. The matter quoted in the Prevention of Future Deaths report was one of ten reasons provided within this email:

- *The Trust's new Overdose Operational bulletin was correctly followed*
- *In accordance with that bulletin, the case was referred by the call taker to a clinician*
- *The patient was called back by a SECAmb specialist Mental Health clinician who was able to have a conversation with the patient and conducted a robust first party triage*
- *The patient denied having taken an overdose despite probing*
- *Although the patient stated that she was fine and had not taken an overdose, the Mental Health clinician still decided to send an ambulance to the patient and upgraded the case from a category 5 non-ambulance disposition to a category 3 disposition, an ambulance attendance with a target response time of two hours*
- *The call has been audited and found to have been compliant, scoring 99/100*
- *The call back to patient by the Mental Health Clinician was made half an hour later than target but this did not have any causal effect; the patient was alert and responsive when called*
- *Although we did not meet our target time to attend the patient after the call was upgraded to a category 3 ambulance attendance, we believed that we were attending not an overdose case but rather a mental health cause for concern case, which may have affected dispatching and clinical queue monitoring decisions*
- *Clinicians advised that paracetamol will not kill a patient within a three-hour timeframe although a paracetamol overdose should still be considered a time sensitive emergency*
- *Correct processes had been followed.*

The report by [redacted] superseded this email in that they provided a section in the report devoted to why the matter had not been declared an SI.

Incidence of acute paracetamol toxicity

Rapid death as a result of paracetamol ingestion is a very rare event. The members of our Serious Incident group, which includes a multi-professional team of consultant and other senior clinicians from medicine, paramedicine and nursing, had not witnessed or encountered this presentation. Our Medical Director and Assistant Medical Director, who are both experienced Consultants in Emergency Medicine, had not encountered any such cases, nor had their Consultant in Emergency Medicine colleagues. It is for this reason that it was stated in the Serious Incident group that patients do not die from paracetamol overdose within a three hour timeframe. Clinicians' experience of fatality following paracetamol overdose is a

slow progression of toxicity over a period of days to weeks, generally as a result of acute liver failure.

Clinical literature supports the rarity of the presentation of acute lactic acidosis arising from mitochondrial inhibition following paracetamol overdose. The attached article from the British Journal of Clinical Pharmacology (BJCP, Shah et al., 2011) refers to 24 reported cases within the literature, reported between 1970 and 2010, of acute lactic acidosis following ingestion of very large quantities of paracetamol. The research found a median of five hours from ingestion to a reduced consciousness level and in 5 of the 24 cases the patient died.

This is triangulated with statistics from TOXBASE.org, the national toxic substance database, showing that paracetamol had by far the greatest number of enquiries to their website, app and telephone advice service in 2019-20, with over 165,000 enquiries (compared with Ibuprofen in second place with just over 50,000 enquiries). The data reveals that whilst paracetamol overdose incidence is high, acute acidosis as a result is extremely uncommon.

I note that in preparing for the inquest, the Trust's clinical team considered both clinical literature and the contemporary guidance on the management of paracetamol overdose. Toxbase (2017) provides the guidance for healthcare in the UK on overdose. The relevant guidance sheet for "*Paracetamol overdose ingested over a period of one hour or less - presenting less than 8 hours after acute ingestion*" was reviewed (TOXBASE.org, 2020). This guidance describes coma and severe metabolic acidosis as "*extremely rare*" and the recommended care pathway for paracetamol ingestion is "*Wait until 4 hours from the last ingestion. Then take a venous blood sample for urgent measurement of the plasma paracetamol concentration from all patients. Plasma concentrations measured less than 4 hours after ingestion cannot be interpreted.*". This information sheet was, I understand, presented to the court for information.

Whilst provided in good faith, I recognise that the statement within the email of 12 October 2020 was not helpful to the court, and I apologise to Ms Codling's family and friends for this.

Action that SECAmb has taken/proposes to take

We have:

1. Raised a formal issue with NHS Pathways (reference [redacted]) to it to consider the matters raised at inquest
2. Brought this case to the attention of the National Ambulance Service Medical Directors
3. Discussed the case with the NHS England / NHS Improvement national clinical lead who is writing a new framework on triage and clinical oversight in EOC of overdose cases
4. Discussed with the Vice President of the Royal College of Emergency Medicine whether they would flag this issue as a 'Safety Alert'. The response was that in light of the rarity of this presentation and possible confounding factors, he does not believe that a Safety Alert would be appropriate.

We further propose to:

5. Meet the NHS England national ambulance team
6. Meet NHS Pathways to share learning and progress the concerns we have already raised on the Pathways issue log. Revised guidance on overdoses is at the pre-publication stage (see attached email from [redacted]). This will endorse clinical review of overdoses, with the intention of upgrading the call if appropriate. There will remain a degree of discretion on the part of clinicians.

After careful consideration, we do not believe that it is feasible to upgrade all overdoses, including paracetamol overdose, to a C2 disposition, as this would have a deleterious effect on responses to those patients who are confirmed as requiring this level of response through presenting with a potentially life-threatening complaints.

We have also considered whether any further internal training is indicated. Taking into account the rarity of this presentation, the very limited volume of clinical information available and the competing demands on limited training time, we have concluded that further escalation is not indicated but rather that reliance on the Joint Royal Colleges Ambulance Liaison Committee guidelines and Toxbase should continue.

Finally, I would like to reiterate my reassurance that we have taken this case very seriously, we prepared a detailed report pre-inquest and we have sought to learn what we can both before and after the inquest. We have already implemented best practice and continue to take intentional/unintentional overdoses, self-harm and suicide extremely seriously.

Yours sincerely

[redacted]

Chief Executive Officer
South East Coast Ambulance Service NHS Foundation Trust

Encs: Report for inquest by [redacted]
Email from [redacted]