Association of Ambulance Chief Executives
25 Farringdon Street
London
EC4A 4AB

[redacted]
W: www.aace.org.uk

29 November 2021

[redacted]

Senior Coroner – Emma Whitting
Bedfordshire & Luton

Dear Ms Whitting

REGULATION 28: LEON BRIGGS

I am writing in response to the Regulation 28 report to prevent future deaths concerning the death of Leon Briggs which you issued on 4th October 2021 to [redacted] chair of the Association of Ambulance Chief Executives (AACE). Please note that as Managing Director of AACE, I am responding on his behalf.

AACE is a private company owned by the English Ambulance NHS Trusts. It exists to provide ambulance services with a central organisation that supports, co-ordinates and implements nationally agreed policy. Our 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 possess the intellectual property rights of the Joint Royal Colleges Ambulance Liaison Committee UK ambulance service clinical practice guidelines (the "JRCALC guidelines"). AACE is not constituted to mandate or instruct ambulance services however it has national influence via the regular meetings of ambulance Chief Executives and Trust Chairs along with a network of national specialist sub-groups. One of its specialist sub-groups is the National Ambulance Service Medical Directors (NASMeD); this response is from AACE having been informed by NASMeD.

With regard to your matter of concern about the adequacy of the local S136 Multi-Agency Policy. We are unable to comment on local S136 policy, but we can confirm that the national S136 guidance has recently been revised, updated, and issued nationally. The revised guidance includes wording to highlight that the police officer on scene should call the local ambulance service and include in the information passed whether the patient is being actively restrained and if so how, and if acute behavioural disturbance (ABD) is suspected. Ambulance trusts will assign a Category 2 response to patients detained under S136 and suspected of having ABD unless there are other immediately life-threatening clinical features that would warrant a Category 1 response.

The national S136 guidance highlights that ambulance services must involve a clinician in any call where a patient is being actively restrained so that clinical support can be provided and the patients vital signs monitored. The revision also includes wording to highlight the fact that if a patient is restrained incorrectly there may be an increased risk of positional asphyxia, so it is vital that the patient's airway and breathing is carefully monitored at all times during restraint.

AACE works closely with the police via the National Police Chiefs Council (NPCC) and liaises with them on a regular basis. We have emphasised the importance of direct contact from the officer on scene to the ambulance control and suggested that police forces explore with their ambulance trusts how this can be established if not already in place.

[redacted]

With regard to your matter of concern around lack of sufficient training for police officers, ambulance crew and other front-line responders and the critical issues of recognising and responding to a medical emergency and the effects of restraint. We are unable to mandate the training that is required, nor the depth and degree of training. This is for local ambulance trust determination. However, we are very aware of the need for emphasis on and relevant training in this important area.

In the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) UK ambulance service clinical practice guidelines we developed and published a new guideline around acute behavioural disturbance in December 2019. The guideline highlights the importance of trying to minimise physical restraint for fewer than ten minutes and avoid airway or respiratory compromise. We are aware that factors have been proposed as contributory to sudden death in ABD and other types of intoxication such as amphetamines, positional asphyxia secondary to restraint, drug toxicity itself or underlying cardiac disease resulting in cardiac arrhythmias. We suggest that provided there is not an immediate risk to life, verbal de-escalation should be attempted before restraint or pharmacological agents are used. We emphasise that clinicians on-scene are responsible for the clinical safety of the patient at all times and should immediately inform any other personnel on-scene if they believe the patient's clinical condition is at risk of deteriorating, particularly if there is any restriction to the patient's airway or breathing. The first healthcare professional on scene should be specifically responsible for monitoring and treating the patient. Any other healthcare professionals or ambulance staff in attendance should be closely liaising with the designated police safety officer. During restraint, clinicians should be prepared for a rapid deterioration in the patient's condition, including cardiovascular collapse. On 1st February 21 we updated the acute behavioural disturbance guidance with wording to emphasise the need for close monitoring of a patient when restraint is used and that the clinician is clinically responsible for the patient.

We have also developed national JRCALC guidance around Mental Health Presentations including Crisis, Distress and Disordered Behaviour. In this guideline, we also have a section highlighting the risks of physical interventions including restraint.

I trust that this response addresses your concerns. If I may be of further assistance, please do not hesitate to make contact.

On behalf of AACE, I would like to extend our sincere condolences to the family of Leon Briggs.

Yours sincerely

[redacted]

Managing Director

[redacted]