Adrian Farrow
Manchester South Coroner's Court
1 Mount Tabor Street
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SK1 EAG

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

2nd February 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Claire Nicole Briggs who died on 28 November 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 December 2023 concerning the death of Claire Nicole Briggs on 28 November 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Claire's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Claire's care have been listened to and reflected upon.

Your Report raises the concern that there is no national guidance as to how high-risk drug overdoses should be identified by ambulance services. Ambulance Emergency Operation Centres (EOCs) follow specific principles to ensure clinical oversight for patients calling and presenting with overdose and suicidal ideations. On 2 April 2019, Professor Jonathan Benger – then National Clinical Director for Urgent and Emergency Care at NHS England – wrote to ambulance trusts and NHS 111 providers to mandate that robust clinical oversight was in place in control rooms to monitor self-harm and suicidal patients safely and effectively.

In 2020, the Healthcare Safety Investigation Branch (HSIB), investigated the potentially under-recognised risk of harm from the use of propranolol. They made a safety recommendation for NHS England to evaluate current approaches to clinical oversight of overdose calls within ambulance control rooms, and to develop a national framework to describe requirements for appropriate clinical oversight of overdose calls.

NHS England issued guidance for Ambulance Services relating to overdoses and suicidal intent in April 2021. The internal guidance sets out that, where an overdose is declared, further clinical intervention should take place, or the case should be automatically upgraded if this does not occur within a specified time (30 minutes). To enable this process, NHS Pathways introduced a distinct disposition code in April 2019: Emergency Ambulance Response for Risk of Suicide (Category 3). This means these cases can be more effectively and rapidly picked out by clinical advisors at the ambulance service.

The overdose guidance was updated in November 2023 to include callers who reach a Category 5 code for overdose/accidental ingestion or a potential threat of suicide to

ensure that the control room have a similar process to that for Category 3 requirements for overdose and suicidal intent patients. This followed a review by the Emergency Call Prioritisation Advisory Group (ECPAG, NHS England) and the National Ambulance Service Medical Director's Group (NASMeD, Association of Ambulance Chief Executives) to ensure it remained fit for purpose.

Ambulance response dispositions within primary triage systems (e.g. NHS Pathways) are reached based on symptom assessment, and where this relates to a suicide attempt, or where there is a finding of suicidal intent, the lowest disposition that can be reached within NHS Pathways is a Category 3 emergency ambulance response. More urgent ambulance dispositions may be reached where immediately life-threatening symptoms or features are present e.g., loss of consciousness or difficulty breathing.

NHS England recognises the significant pressure on ambulance services since the Covid-19 pandemic, which has seen longer response times across all categories than before the pandemic. That is why NHS England have continued to focus on improving ambulance performance for 2023/24, supported by the Delivery Plan for Recovering Urgent and Emergency Care Services, published in January 2023. The plan outlines the actions and steps that we are taking across England to recover and improve urgent and emergency care services, including improving ambulance response times, increasing ambulance capacity through growing the workforce, speeding up discharges from hospitals, expanding new services in the community, and taking steps to tackle unwarranted variation in performance in the most challenged local systems.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

Yours sincerely,

[redacted]

[redacted]
National Medical Director