NHS
North East
Ambulance Service
NHS Foundation Trust

Strictly Private and Confidential
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His Majesty's Coroner for Teesside
The Coroner's Service
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[redacted]

Date: 9 February 2024

Dear Ms Bailey,

Inquest into the death of John Robert Taylor

Regulation 28 – Report to prevent future deaths

I am writing in my role as Chief Executive of North East Ambulance Service NHS Foundation Trust ("NEAS") and in response to the Regulation 28 report for the prevention of future deaths dated 15 December 2023 as issued by you following the inquest into the tragic death of John Robert Taylor.

The matters of concern listed in your report are: -

1. The attending paramedics had not adequately checked the door handle. It was unlocked. As a result, they waited an extra 30 minutes for the police to arrive in order to gain entry.

2. The circumstances surrounding the failure to adequately check the door handle was not offered or elicited within the internal investigation. Subsequently it was not reported to the SI author. This issue was not considered within the SI.

3. Consideration was not given to the possibility of sending a taxi to Mr Taylor so he might be conveyed to hospital quickly.

We were disappointed to have received a Regulation 28 report in relation to this inquest. Two management witnesses from NEAS attended the inquest and provided verbal evidence alongside the documentary evidence previously disclosed. Evidence was introduced during the inquest which NEAS had no prior knowledge of, specifically in respect to the Police log and the previous use of taxis for Mr Taylor. NEAS did not have Properly Interested Person status at the inquest nor received the evidence bundle from other organisations. Had we understood your concerns we would have applied for Properly Interested Person status and would have been able to provide further evidence and an appropriate management witness statement to address the concerns in advance of the inquest.

We will address each point you have raised in your matters of concern below: -

1. **The attending paramedics had not adequately checked the door handle. It was unlocked. As a result, they waited an extra 30 minutes for the police to arrive in order to gain entry.**

   Since learning this information during the inquest, we have received disclosure of the Police STORM Log and made enquiries with Cleveland Police colleagues. In addition, we have spoken with the attending NEAS crews and obtained a further account knowing the information disclosed.

   Cleveland Police colleagues have spoken with the Officers who attended the scene in July 2022. The feedback provided is that one of the Officers went to try the door whilst his colleagues retrieved the method of entry equipment from the police vehicle. The Officer trying the door has confirmed the door was unlocked and did not require forcible entry. This is supported by the second Officer who has responded to the query even though they have left the force. Our inquiries have not found any contact with NEAS to raise concerns following the incident nor raised with the attending NEAS crew.

   In respect to enquires made since the inquest, we have reviewed the call made to the NEAS Emergency Operations Centre by the attending crew. The call is very clear with a member of the crew clearly explaining the efforts made, including checking the door, knocking on windows/door and shouting though the letter box, which were consistent with the written witness statement. One of my senior leadership team has met the crew and raised the matter in respect to the information provided by the police. The recollection of events from the crew is consistent with their witness statements with both crew members stating they had tried to open the door. This accords with the details passed during the conversation with the NEAS Emergency Operations Centre. Upon speaking with the individual crew members, they both advised that on arrival of the police officers they gathered their equipment and just heard a comment from the police officers stating the “door was now open”. At this stage the crew immediately entered the property to assess and treat the patient.

   The crew have advised that at no stage did the attending police officers advise the door was unlocked nor did they make any complaint to the crew.

   It is not possible to fully explain what happened on scene, on balance it does however appear to be a misunderstanding by the NEAS crew, in so far as the comment the “door is open” meant the door was already open and did not require the police to gain entry by force.. This has been picked up with the NEAS crew and feedback provided that the door was unlocked and that every effort should be made before calling for assistance. I will go onto provide details of the wider improvements made in this respect.

Whilst not directly linked with this case, the Trust have continued to work with other emergency service colleagues in respect to gaining entry. We have an established Memorandum of Understanding (MOU) in place with Northumbria Police, Tyne and Wear Fire and Rescue and Northumberland Fire and Rescue Services. The MOU specifically covers forcible entry and has proven very successful since its inception in 2016. Efforts have continued to extend the MOU into County Durham and Darlington and Cleveland but further work is required as partners are not currently able to commit. I can however assure that this remains a point for discussion and has been escalated with senior colleagues in those organisations. NEAS are not able to mandate this arrangement but continue to advocate the positive impact the MOU has made in other parts of the region.

In addition to the ongoing efforts to extend the MOU, the Trust have recently, October 2022, provided refresher training to managers within the Emergency Operations Centre (EOC) to ensure that their teams/staff follow the agreed process for cases where forcible entry may be required. This includes the arrangements in place via the MOU and also those areas were the primary support for forcible entry remains with the police. This is certainly the case within Cleveland. I have enclosed a copy of the current version of the MOU for your information, albeit this is not currently within the Cleveland area however the same principles for checking doors, windows and neighbours remain the same for our attending crews in the Cleveland area. There is an update currently being applied to the MOU detailing the improvements to the process which is proceeding through the ratification process.

The refresher training provided to the EOC managers ensures that they have overall oversight of all cases in which a forcible entry request is being made. The improvements ensure that the EOC supervision can ensure that operational staff have made all reasonable efforts to gain entry to the property prior to the request for police or fire and rescue services to force entry. There are some exceptions to this process, such as in the case of a Category 1 response where it is clear from the outset of the call that forcible entry will be required, it will be requested by Health Advisors.

NEAS currently has several methods of communication in relation to updates and changes to practice depending on the service line. Operational alerts are used to communicate with operational teams, supported by internal communication platforms. EOC staff are provided with training bulletins, guidance notes and memos, whilst also being supported by the same communication platforms.

I have enclosed a copy of the updated Standard Operating Procedures (SOPS) for Unscheduled Care Dispatch Staff. The overarching SOPS include an update in relation to forcible entry at pages 83 and 84, plus show the wider processes for completeness. The updated SOPS were cascaded on 4 February 2024. In addition to the SOPS, an Operational Alert has been issued to operational staff, I have enclosed a copy of the alert which was cascaded on 7 February 2024. In addition updated guidance for Call Handling staff was shared on 8 February 2024 which I have enclosed.

In respect to wider collaboration with emergency service colleagues, members of the Trusts management team host and chair the Regional Joint Partnership Management Group (JPMG), which consists of senior representatives from the regions 3 Police forces and the 4 Fire and Rescue Services. We have enclosed the terms of reference for this group which will assist with understanding the purpose and matters which are discussed. One of the standing agenda items, relates to any matters which require raising for the attention of any service.

This would include concerns/issues such as those associated with forcible entry. In addition, NEAS also chairs a multi-agency control managers meeting, with membership including control managers from each service. A similar standing agenda item in relation to matters for attention is also included in that group.

In respect to the escalation/sharing of issues between partners this will be discussed at the JPMG meeting on Monday 12 February 2024. The chairperson of the meeting was in attendance at the inquest and spoke with the NEAS crew as well as liaising with a colleague to contact Cleveland Police for their Officers recollections. The process for escalation/sharing issues will be discussed using this case as an example to reinforce the importance of escalation and sharing any issues and/or learning. In addition to this agenda item, we have added the updated draft MOU for consideration by the partners. This is currently focused on those organisations linked with the current MOU, however it is hoped that it may help push the wider adoption of the MOU in Cleveland and County Durham

2. **The circumstances surrounding the failure to adequately check the door handle was not offered or elicited within the internal investigation. Subsequently it was not reported to the SI author. This issue was not considered within the SI.**

The information contained within the Police STORM Log was not previously disclosed or shared with the Trust and therefore the investigating officer did not consider this matter within the serious incident investigation report. Statements were provided by the attending NEAS crew which covered efforts to gain entry and consider the delay in gaining entry as per the request from your Officer. The witness statements provided did not mention that the attending Police Officers had found the door to be unlocked nor did Cleveland Police raise the matter with the Trust. Had the Investigating Officer and indeed other colleagues known this information then further enquiries would have been made during the investigation, whilst requesting witness statements from the attending crews.

As mentioned above, we intended to reiterate the importance of raising/sharing issues between partners to ensure we continue to learn and improve from any issues. It is essential that we understand any challenges faced by our crews so we can learn lessons and review processes and considerations such as training, communication and related matters.

3. **Consideration was not given to the possibility of sending a taxi to Mr Taylor so he might be conveyed to hospital quickly.**

Further to the comments made by the family during the inquest and the subsequent concerns you have raised. We have undertaken a review of the calls received from Mr Taylor between 1 April 2021 and 19 July 2022, between these dates we received a total of fifteen 111/999 calls. The records show that on one occasion a taxi was used for transportation albeit, this was an urgent booking made via the patients GP who advised of the appropriate transportation. The below is a summary of those calls and the resources allocated as a response.

16/04/21 – 111 call was made by the patient which was triaged with advice to make their own way to Hartlepool Urgent Care Centre.

19/04/21 - Urgent case booked by GP advising transportation via Patient Transport Service (PTS) is suitable. A double crewed PTS resource transported the patient to North Tees Assessment Unit from the home address.

30/04/21 -111 call was made by the patient which was triaged with advice to make their own way to Hartlepool Urgent Care Centre.

30/04/21 - Urgent case booked by GP for patient with, chronic pancreatitis, *advising transportation via Patient Transport Service (PTS) is suitable. A taxi was requested and transported the patient to North Tees Assessment Unit from the home address.*

30/04/21 - 999 call made by the patient which was triaged as a Category 1 emergency ambulance response. Two double crewed emergency ambulances attended scene, remaining with the patient for one hour before leaving the patient at home with advice.

01/05/21 – linked with above call, 999 from Cleveland Police to advise that they are not travelling.

02/05/21 - 999 was made by the patient which was triaged as a Category 3 emergency ambulance response. Call is upgraded to a Category 2 emergency ambulance response after a clinician call. A double crewed emergency ambulance attended and transported the patient to North Tees Hospital.

05/05/21 - 999 call received from a nurse which was triaged as a Category 2 emergency ambulance response. A double crewed emergency ambulance response attended and transported the patient to North Tees Hospital.

28/07/21 - 999 call received from a GP which resulted in a Category 2 emergency ambulance response. A double crewed emergency ambulance arrived on scene, treating the patient on scene without onward transportation.

10/08/21 - 999 call was made by a relative, from a different address, which was triaged as a Category 1 emergency ambulance response. One double crewed emergency ambulance and a support vehicle attended treating the patient before leaving at scene.

31/08/21 - 999 call was made by the patient which was triaged to a Category 2 emergency ambulance response. A doubled crewed emergency ambulance attended and transported the patient to North Tees Hospital.

01/11/21 - 999 call was made by the patient which was triaged as a Category 2 emergency ambulance response. A double crewed emergency ambulance attended and transported the patient to North Tees Hospital.

04/03/22 - 999 call received from a GP which resulted in a Category 2 emergency ambulance response. A doubled crewed emergency ambulance arrived on scene and transported the patient to North Tees Hospital.

06/07/22 - 999 call was made by the patient and triaged as a Category 2 emergency ambulance response. A double crewed emergency ambulance arrived on scene and transported the patient to North Tees Hospital.

18/07/22 - 999 call received from Cleveland Police which was triaged as a Category 3 emergency ambulance response. Two double crewed emergency ambulances attended scene, with one as backup at the request from the first crew. The patient was transported to North Tees Hospital.

In considering bookings for transportation made via the Patient Transport Service (PTS), upon checking the records covering the same period, we have two bookings made as follows:

13/10/2021 – Booking made via a GP for transportation from the patients home address to an outpatient's appointment at Newcastle Freeman Hospital. The transportation was provided by a Patient Transport Service car.

13/10/2021 – Booking made via a GP for transportation from Newcastle Freeman Hospital back to the patients home address following the outpatient's appointment. The transportation was provided by a Patient Transport Service car.

During the inquest you heard verbal evidence from a NEAS Clinical Section Manager who advised that in respect to the call on 18 July 2022, a taxi was not considered and would not have been appropriate given the nature of the call. The review of the clinician's call undertaken by another Clinical Section Manager, shows that some red flags existed and should have prompted a higher level of caution, therefore the use of a taxi would not be appropriate. This was on the basis that the caller was expressing suicidal intent and plans, therefore not safe or appropriate to send a taxi in these circumstances. We have previously disclosed this report to your office and this was covered during live evidence by the Clinical Section Manager attending the inquest. The Management of Long Waits procedure which was disclosed provides details in respect to use of alternative transport following an assessment by a clinician.

Section 7.1 of the procedure states: *"the trust has deemed that where, following assessment, a patient is clinically suitable to travel in a non-blue light transport, such as a taxi or PTS vehicle, i.e. requires no clinical intervention or supervision, able to sit in a car and transfer in and out of a car with minimal assistance and where all other options have been exhausted (self-conveying or relative); a Trust approved alternative conveyance may be organised by the clinician.*

In respect to the concern that a taxi was not considered, given the red flags and nature of the call, a taxi would not be appropriate for this type of call and therefore is not mentioned in the call notes as the case remained a Category 3 emergency ambulance response.

In relation to the Management of Long Waits Policy, this policy was removed from use on 25 August 2022 and was replaced with the Procedure for Emergency Ambulance Response Validation and was implemented on 25 August 2022. The new procedure provides a process whereby welfare calls are only required to be made to patients who are alone. In these cases, the clinician is required to update the notes to make it clear when viewing the case list whether a welfare call is required or not by documenting 'welfare' or 'no welfare'.

The changes were introduced following a Quality Improvement process based on evidence which showed only a small proportion of calls were receiving a welfare call. It was felt that the greater risk related to patients who are alone not receiving a call, versus a patient who has someone present receiving a call. If a similar scenario was dealt with now, the patient would receive a welfare call based on the updated procedure to prioritise those patients who are alone.

The Emergency Ambulance Response Validation procedure also includes a section on alternative transport which is at section 1.5, page 3 of the procedure which is enclosed.

Section 1.5.1 states: "*If during a validation call, it is identified that alternative transport can* be utilised, e.g. urgent crew, scheduled care crew, or taxi the instructions field will be populated with ALT in addition to the time of the validation and this will notify the dispatch team that alternative transport can be utilised. The clinician will document in the case notes the type of transport required and the patient's mobility".

Section 1.5.2 states: "*If a crew has been allocated to a case and alternative transport is appropriate, the save and notify function should be used to notify the dispatch team that an emergency vehicle is not necessary*".

As you will note the current procedure includes the requirement to add notes to the system to identify that alternative transport can be utilised and what type is required based upon their assessment.

I hope that this addresses the matters of concern which you have highlighted. If we can be of any further assistance then please do not hesitate to contact [redacted]

Yours sincerely

[redacted]

[redacted]
Chief Executive

Enclosures:

Forcible Entry Memorandum of Understanding (current)
Standard Operating Procedures (SOPS) for Unscheduled Care Dispatch Staff
Operation Alert – forcible entry
Forcible Entry Guidance Note – Call Handling Staff
Joint Partnership Management Group Terms of Reference
Emergency Ambulance Response Validation Procedure