Michael Wall
Nottinghamshire & Nottingham
HM Coroner's Service
The Council House
Old Market Square
Nottingham
NG1 2DT

[redacted]

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

[redacted]

26th April 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Daniel Mark Edward Tucker who died on 22 April 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 February 2024 concerning the death of Daniel Mark Edward Tucker on 22 April 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Dan's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Dan's care have been listened to and reflected upon.

In your Report, you addressed a concern to NHS England that confirmed ingestion of [redacted] during a 999 call does not trigger a Category 1 ambulance response.

Ambulance Emergency Operation Centres (EOCs) use one of two approved triage tools to take 999 emergency calls – Medical Priority Dispatch System (MPDS) or NHS Pathways. At the time of the calls being made to East Midlands Ambulance Service NHS Trust (EMAS) in Dan's case, EMAS were users of the protocols within the MPDS, for which there is a protocol. This protocol generates a specific 'Determinant Code' for overdose, following the initial assessment of the patient. This then allows the relevant Ambulance Emergency Operation Centre (EOC), in this case that of EMAS, to consider the Determinant Code and locally determine and apply a local response mode or 'Category'. The response modes are underwritten by the UK Government Emergency Call Prioritisation Ambulance Group (ECPAG) and sent to NHS Ambulance Service Trusts in England for implementation.

While ingestion of [redacted] can lead to fatality, this can unfortunately be said of an array of substances, ranging from prescription medicines to over-the-counter household products and other agents available commercially or over the internet. The MPDS does specifically code some common overdose/poisoning agents, but this is for the provision of specific therapies and information for responders rather than for specific response assignment.[1] The listing of all possible fatal agents would likely lead

[1] NHS Pathways, the alternative triaging system, also has a disposition code to facilitate improved visibility of overdose and suicide attempt cases within the ambulance dispatch code. It also provides a

to significant over-triage and delay as many of these patients are asymptomatic and do not represent *pre-arrival* emergencies. Additionally, the type and amount of substance taken is not always reliably obtained as patients attempting suicide can mislead responders. Therefore, listing specific agents and amounts with the expectation that non-clinician Emergency Dispatchers make response assignment decisions based on what may well be inaccurate information would likely result in significant and potentially dangerous triage practice. The BRAVO-Level code assigned to intentional overdose (intent to harm self) cases, specifically patients without priority symptoms, is intentionally isolated so that agencies can prioritise intentional acts and respond appropriately, regardless of the substance information offered by the caller.

Due to the broad spectrum of potentially dangerous substances that can be ingested by members of the public, either intentionally or accidentally, coupled with the urgent and emergency care (UEC) challenges and delayed response times currently faced by the NHS, it is recommended by the MPDS (and NHS England, please see below) that ambulance trusts utilise trained clinicians in the control center to advise further on the potential effect of ingestions and upgrade responses if deemed necessary. The MPDS also has protocols for overdose patients as well as those patients with mental health conditions that are suffering any self-harm or suicidal thoughts. Since the time of this call, specific training and a new protocol have been developed specifically for first party callers in crisis.

EOCs follow specific principles to ensure clinical oversight for patients calling and presenting with overdose and suicidal ideations. These principles have been reviewed and strengthened through several national recommendations since 2019, see below.

Firstly, on 2 April 2019, [redacted] – 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 and call centres to monitor self-harm and suicidal patients safely and effectively.

Secondly, 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 guidance highlights the critical importance of clinical oversight and review and 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).

---

telephone consultation tool called Pathways Clinical Consultation Support System (PaCCS). This is for use by experienced clinicians and lends itself more to a consultation-led assessment rather than triage

- it is good practice for TOXBASE® (clinical toxicology database) to be viewed for each overdose / accidental ingestion incident, despite the familiarity of the reviewing clinician with that particular toxicity profile, which includes [redacted]. It is noted that management practices often change in relation to specific toxins, therefore guidance around the use of TOXBASE ® was issued instead.

- the initial clinical review should also consider any ongoing suicidal ideation with a specific plan / means.

Most recently, the overdose guidance was updated in November 2023 to include callers who reach a Category 5 disposition (hear and treat). 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 clinically fit for purpose.

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,

[redacted]

[redacted]
National Medical Director