OUR SERVICES
Urgent and Emergency Care
Patient Transport Service
NHS 111

NHS
North West
Ambulance Service
NHS Trust

Mr Matthew Cox
His Majesty's Assistant Coroner
Greater Manchester North

BY EMAIL ONLY

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Dear Mr Cox

Regulation 28 Report – Inquest Touching the Death of Mr Paul Dow

I write further to your Prevention of Future Deaths Report which was issued to North West Ambulance Service ('NWAS') following the conclusion of the inquest touching the death of Mr Dow.

I know that you will share my response with Mr Dow's family, and I firstly wish to express my sincere condolences to them.

NWAS' core purpose is to save lives, prevent harm and provide services which optimise the likelihood of positive patient outcomes.

Through the Regulation 28 report, you have requested that NWAS considers your matters of concern and have suggested that action is taken to prevent future deaths occurring in the future. By this letter, I will address those concerns as far as I am able to.

1. **Despite a clear indication from Mr Dow that he had taken an overdose of a lot of medication with an indication that he did so to take his own life, the calls at 18:35 and 19:38 were both coded as category 3.**

Based on the information provided by him in response to the call handler's questioning during both 999 calls made to NWAS, the outcome elicited by NHS Pathways for Mr Dow's 999 calls was a category 3 response.

The categorisation of emergency 999 calls, which are triaged through the NHS Pathways system, is standardised across England in all ambulance Trusts which use the Pathways system. Whilst ambulance Trusts can (and do) provide feedback to NHS Pathways with views/opinions on call categorisation, the decision as to categorisation is ultimately a decision for NHS Pathways.

The triaging of calls involving an overdose of drugs (whether intentional or not) will result in a minimum categorisation, via Pathways, of a category 3 response. Individual factors relevant to the patient may indicate a more urgent threat to life and can result in an increased level of categorisation, if appropriate, based on the answers to the questions asked by Pathways.

In Mr Dow's case, both calls made to NWAS have been audited and the outcome was that the eliciting of category 3 responses was appropriate.

2. **There was no involvement of a clinician at the time of either call.**

At the time of his first call, Mr Dow was advised that an ambulance was being arranged, however in the meantime a clinician may call him back and that he should ensure his phone line was kept clear.

At the time of these events, all category 3 and 4 calls presented in a 'stack' of calls in the Clinical Support Desk ('CSD') within the NWAS Emergency Operations Centre ('EOC'), for review. The CSD is staffed by Senior clinicians who review all waiting category 3 and 4 calls in order to make a decision as to whether the call is appropriate for ambulance dispatch or whether further telephone triage is required.

In Mr Dow's case, this initial review by a CSD clinician determined that further telephone triage was required and therefore the call was passed to the Specialist Practitioner team within the EOC, which is staffed by Advanced Paramedics and Nurses.

One of the Specialist Practitioners subsequently tried to contact Mr Dow on three occasions as per NWAS procedure. Unfortunately, as you are aware, those calls went unanswered. A clinical decision was then made for an ambulance to be dispatched in time order to Mr Dow. It was open to the Specialist Practitioner to upgrade the response, however, based on the information available, they made a clinical decision based on the information available not to do so.

Accordingly, there was a clinician review of Mr Dow's call at 18:35 on two occasions, firstly by the CSD clinician and secondly by the Specialist Practitioner who subsequently attempted to contact Mr Dow.

Following the further 999 call at 19:38, Mr Dow was re-triaged through the Pathways system and again, a category 3 response was elicited.

As the decision had already been made by the Specialist Practitioner to dispatch an ambulance the call was not passed for further clinician review.

3. **Mr Dow was on his own in the hotel room. When a clinician called on three separate occasions there was no response. During her evidence, Ms Lee, the Service Delivery Manager of the Emergency Operations Centre accepted that this could indicate that Mr Dow had lost consciousness but the call made at 18:35 was not escalated.**

As set out above, when Mr Dow did not pick up the three calls made by the NWAS Specialist Practitioner, the decision was made by that clinician to dispatch an ambulance to him. This was, in and of itself, an escalation of the call, as it had initially been deemed appropriate for further telephone triage.

It is common for return calls from the ambulance service to patients to go unanswered. In that scenario, it is not possible for this to result in an automatic upgrading of calls. Automatically upgrading the categorisation of all calls to patients that go unanswered would have a significant impact in the response the ambulance service is able to provide to patients who have already been triaged at a higher priority (for example category 1 and category 2 calls) and would place a significant burden on the Trust's wider response times for *all* patient incidents, such that the achieving of target response times is likely to become unachievable.

Accordingly, clinical decisions must be made, based on the information available, as to whether a call should be upgraded in the event a patient does not answer calls to them, as happened in Mr Dow's case.

In any event, where contact cannot be made with a patient as occurred in Mr Dow's case, an ambulance dispatch will occur, however the categorisation of that ambulance has to be judged based on the information available.

Changes in Practice

I have also set out below work that has been done within NWAS, since Mr Dow's death, which I hope will

provide you with confidence that the Trust's procedures and processes have evolved, with a view to ensuring patient safety in similar cases.

Review and Triaging of Calls

Since Mr Dow's death, there have been various operational changes within the Trusts EOCs with regards to how emergency calls are dealt with.

Following these changes, calls involving an overdose will remain as a minimum category 3 disposition in line with NHS Pathways categorisation (unless a higher categorisation is reached based on the answers to the Pathways questions on signs and symptoms) but will now be sent for Clinical Navigation. The Clinical Navigation team is made up of clinicians working within NWAS EOCs, who will undertake a preliminary review of the information elicited during the 999 call.

Based on this review the Clinical Navigator will make a decision as to whether the call (1) needs to be upgraded immediately, (2) should remain as a category 3 response and await ambulance dispatch accordingly or (3) requires further triaging. This is now the first line of clinician review in these types of calls and ordinarily takes place within 15 minutes of the 999 call being concluded.

If the decision of the Clinical Navigation team is that a further telephone triage is required, then the call will be passed to the CSD where it will be reviewed by a Specialist Practitioner and a call to the patient will be made to undertake the further triage and the most outcome based on that triage will then be arranged.

In cases of overdose / poisoning, if the further triage by the Specialist Practitioner does not take place within 30 minutes, for example during periods of high demand on NWAS services, the call will pass to the Clinical Coordination Desk ('CCD') for consideration and the Trust's welfare module will be enacted. This can result in (1) an upgrade of the call categorisation, if deemed clinically necessary (2) dispatch of an ambulance in line with the calls current categorisation (3) awaiting further triage by the CSD or (4) immediate triage by a patient safety clinician with the CCD.

At all stages in the process set out above, it is open to the clinicians involved to upgrade a call if they deem it clinically necessary.

Training

In line with the changes made with regards to the review and triaging of calls as summarised above, the Trust's clinicians working in the Clinical Navigation, CSD and CCD teams have undergone extended training on dealing with and reviewing cases of overdose / poisoning, including making use of resources such as TOXBASE® (TOXBASE® is the clinical toxicology database of the UK National Poisons Information Service) to help support clinical decision making when excess medications have been ingested.

This additional and extensive training enables the Trust's clinicians to make appropriate clinical judgments and to ensure that affected patients receive the most appropriate treatment in a timely manner.

I am sorry that you felt it necessary that there was cause to issue a Prevention of Future Deaths Report and I hope that, by this letter, I have addressed your concerns.

Should you require any further clarification or information, please do not hesitate to contact me or the Trust's Head of Resolution, [redacted].

Yours sincerely,

[redacted]

[redacted]

Chief Executive