OUR SERVICES
Urgent and Emergency Care
Patient Transport Service
NHS 111

NHS
North West
Ambulance Service
NHS Trust

LADYBRIDGE HALL
399 Chorley New Road
Bolton
BL1 5DD

T: 0345 112 0999

nwas.nhs.uk

Mr Christopher Murray
His Majesty's Assistant Coroner
Manchester South Coroner's Court

BY EMAIL ONLY

22 November 2024

Dear Mr Murray,

Regulation 28 Report – Inquest Touching the Death of Michael Sean Heath

I write further to your Prevention of Future Deaths Report dated 2 October 2024 which was sent to North West Ambulance Service ('NWAS') following the conclusion of the inquest touching on the death of Michael Sean Heath.

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

Whilst your Regulation 28 report was addressed to multiple organisations, this response is prepared solely on behalf of NWAS. By this letter I will address your concerns as far as I am able to.

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

Within the circumstances of Mr Heath's death section of your report, you note that the jury concluded that a contributing factor to his death was a lack of probing by the NWAS Mental Health Practitioner during a telephone triage on 23 August 2023, which resulted in a missed opportunity for a face-to-face assessment to take place.

I note that oral and written evidence was provided at the inquest on behalf of NWAS by the Mental Health Liaison and Suicide Prevention Lead and a Service Delivery Manager from the Emergency Operations

Centre. It was acknowledged in their evidence that the telephone call between Mr Heath and the NWAS Mental Health Practitioner on 23 August 2023 did not achieve a safe outcome on audit due to a lack of probing. Since the incident involving Mr Heath, the Mental Health Practitioner in question has received feedback regarding the lack of probing and has undertaken reflection.

Turning to the matters of concern within your Regulation 28 report, I note you have raised concerns regarding (1) training of police officers in handling mental health calls (2) the notification of family members of mental health patients who have been admitted under the Mental Health Act (3) the lack of connectivity between mental health services abroad and in the UK (4) risks to patients when they are removed from GP practice lists and (5) means of communication between mental health agencies being known and agreed and relevant patient information being in an accessible central repository.

Unfortunately, as the matters of concern raised at points (1) – (4) relate to other organisations, I will not be able to provide any assistance with those concerns.

With regards to point (5), whilst NWAS is not a mental health Trust, a significant number of calls received by the ambulance service relate to mental health patients, such as Mr Heath, and ensuring such calls are dealt with appropriately to ensure the best outcomes for this patient group is a key aim of NWAS. I will therefore provide some further information on the work NWAS is undertaking with its partner agencies who are also often called upon to assist mental health patients.

I understand in his evidence to the inquest, that the Mental Health Liaison and Suicide Prevention Lead confirmed that the two Manchester mental health Trusts have placed their mental health practitioners within NWAS control rooms, thereby enabling assessment of mental health patients by said practitioners when 999 calls are made to NWAS. This system grants NWAS access to mental health Trust patient records via the mental health Trust practitioners and allows for joined up working between the three Trusts to enable timely care from the most appropriate clinicians.

Owing to staffing difficulties, Greater Manchester Mental Health NHS Foundation Trust (‘GMMH’)’ have not been able to provide any staff to work in NWAS control rooms for several months; however the Greater Manchester Commissioner is working to reinstate GMMH staff into NWAS control rooms as soon as possible. Pennine Care NHS Foundation Trust staff remain deployed in NWAS control rooms 7 days per week.

In addition to the mental health Trust practitioners working within NWAS control rooms, NWAS also employs mental health practitioners directly, who are also tasked with triaging and directing calls from mental health patients into the service.

The implementation of *‘Right Care, Right Person’* across the Greater Manchester area has required NWAS

and its system partners to plan, collaborate and attend workshops / training events to determine how the system will work and how the organisations involved in its implementation will work together to ensure the most appropriate response for mental health patients who require help. *'Right Care, Right Person'* has now gone live across Greater Manchester and NWAS and its system partners regularly meet to discuss the system, its effectiveness and how it can be improved to the benefit of mental health patients in crisis.

Finally, I understand you heard evidence from the Mental Health Liaison and Suicide Prevention Lead about the agreed plans for mental health Trust clinicians and operatives from both NWAS and Greater Manchester Police to co-locate within a shared working space, with a view to ensuring efficient, effective and joined-up working between the three organisations in order to best meet the needs of mental health patients. The go-live date for this is yet to be agreed, however investment in the project has been secured.

I am sorry that you felt it necessary to issue a Prevention of Future Deaths Report and I hope that, by this letter, I have addressed your concerns from the perspective of NWAS.

Should you require any further information or clarification, please do not hesitate to contact me or the Trust's Head of Legal, Resolution and PALS, Mrs Lois Peterson.

Yours sincerely,

[redacted]

[redacted]
Acting Chief Executive Officer