East of England Ambulance Service NHS Trust

Ms Emma Whitting
Senior Coroner for Bedfordshire

East of England Ambulance Service NHS Trust
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

[redacted]

22 November 2021

Dear Ms Whitting

Thank you for your communication regarding the Regulation 28 (Report to Prevent Future Deaths) in respect of the death of Leon Briggs. I would like to offer my condolences to Leon's family and those affected by this tragic event.

I have responded to the points raised in the Regulation 28 report separately below:

1. **Adequacy of the local S136 Multi-Agency Policy**

Whilst the local S136 guidance has changed considerably since the death of Leon, in my view, it is still not fit for purpose for the following reasons: (i) It requires streamlining and re-formatting (including the use of a larger font) to make it easier for all agencies to follow – it may assist to focus on multi-agency activities ONLY (leaving individual agencies to provide their own specific policies to support the multi-agency interaction) (ii) Reference to other regulations might best be avoided (see for example 3.3) so that it can stand as freestanding guidance for those attending fast moving incidents to apply without delay; (iii) The guidance should closely follow the chronology of a relevant incident i.e. it should start with the decision to detain, followed by the relevant risk assessment, appropriate conveyance, place of safety etc. Information regarding permitted periods of detention and roles and responsibilities could be dealt with at the end.

You also suggested that agencies work with an expert in this field to facilitate these improvements.

The National Ambulance s.136 Guidance was recently approved (November 2021) by the National Ambulance Service Medical Directors group (NASMED), which is a working group that reports to the Association of Ambulance Chief Executives (AACE). These changes will now be implemented locally and this work is being led by the Bedfordshire AMHPs (on behalf of the Crisis Care Concordat) and the forum includes representation from both EEAST and Bedfordshire Police.

The updated national guidance highlights that the police officer on scene should indicate if ABD is suspected and if the patient is being restrained. Nationally, the agreement is that these patients will warrant a Category 2 response as a minimum. Within EEAST, the decision has been made that patients who are detained under s.136 and being restrained by the police will be treated as Category 1 calls in line with the attached EOC Standard Operating Procedure. The national

guidance also directs ambulance services to ensure a clinician is involved in the call and highlights the risk of positional asphyxia if the patient is being restrained incorrectly.

EEAST's Mental Health team have also been working on updating the guidance documents for our partners in relation to managing s.136 patients within the community setting. This document 'Requesting Conveyance for Patients Detained under the MHA' will be sent to you once the review and update has been completed in December 2021. This will also be shared with the regional police forces and mental health partners through the regional Approved Mental Health Practitioner.

2. **Lack of Sufficient Training for Police Officers, Ambulance Crew and other Front-Line Responders.**

   Although, the MHCCC Strategic Group are progressing joint training for all first responders including hospital staff who might need to assess medical fitness and/or treat S136 detainees, it was clear from the evidence heard at the Inquest that there remains insufficient or inadequate instruction of both police and ambulance crew about the critical issues of recognising and responding to a medical emergency and the effects of restraint including positional asphyxia. Consideration, therefore, needs to be given by National and Local Police and Ambulance services as to whether the current individual service training (including refresher training) is adequate (and of similar level to that provided to those working in Mental Health Units pursuant to the Mental Health Units (Use of Force) Act 2018) to ensure the welfare and safety of S136 detainees.

Since this inquest, EEAST's Mental Health Team have worked collaboratively with the NHS partner organisations across the East of England to develop and implement a new mental health care service model. The manager's briefing relating to this new model has been attached with this letter and outlines the changes that have been made. Our chosen service model is to establish an EEAST Mental Health team that is based within the operational setting, working alongside our clinicians and linking with system partners. Through this model we hope to deliver relevant training, identify and improve access to appropriate care pathways and increase the confidence of our staff in the assessment and management of presenting mental health need across the organisation.

EEAST has also developed a specific training session in relation to Acute Behavioural Disorder, including positional asphyxia. The commencement of this training session is planned for 2021/2022 for all frontline staff across EEAST as part of the Essential Care Skills, which is EEAST's annual clinical update.

In addition to this, in July 2021, the Mental Health Team reviewed and re-published the following pocket guides to all frontline staff: What is s.135/136; Mental state examination; Mental Health Act v Mental Capacity Act. The dissemination of these guides was supplemented by a video for staff to view. Further pocket guides relating to ABD and conveyance of mental health patients are in progress and will be published and shared with all patient-facing staff over the coming months.

I hope this letter demonstrates the steps the Trust is taking to improve our response and care delivery to patients who may be detained and the associated risks that may arise when attending to these patients. Please do not hesitate to contact me should you require a further update.

Yours sincerely

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Chief Executive

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