South Western Ambulance Service NHS
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Dr Emma Carlyon – HM Senior Coroner
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Sent via recorded delivery and secure email to
[redacted]

25th July 2016

Dear Dr Carlyon

Prevention for Future Deaths report - Mr William Nute

I write further to receiving your report under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, following the inquest into the death of Mr William Nute.

In your report, you set out the circumstances of Mr Nute's death and identify some concerns you feel were not fully addressed during the Inquest earlier this year. I will endeavour to deal with each point raised in turn.

In terms of the delay in the paramedic crews attending Mr Nute, it is acknowledged in the report compiled by [redacted] (Senior Dispatcher), a copy of which was submitted in evidence for the inquest, that a 999 call was received at 11.45 on 30th June 2015. As indicated in the report and indeed during the hearing, it appears there was initially some confusion on scene as to whether Mr Nute had been hit by a reversing car travelling at slow speed, or whether he had simply fallen.

Once it had been confirmed to the call handler that the bystanders believed he had been hit by the car, a Rapid Response Vehicle (RRV Solo Responder) was allocated to attend at 11.50. The disposition reached was a Green 2, with a target response time of 30 minutes. Furthermore, a Double Crewed Ambulance (DCA) vehicle was also dispatched at 11.52.

Unfortunately, I understand both the RRV and DCA were stood down because they were diverted to higher priority calls i.e. Red 2 8 minute response patients, who may not have been conscious or breathing and so were time critical. Following a second 999 call at 12.16 and reports of a deterioration in Mr Nute's symptoms, the disposition was upgraded to a Red 2 8 minute response. A RRV was subsequently allocated at 12.21 and arrived on scene at 12.35.

It is accepted that the first response on scene was some 50 minutes after the call was received and 20 minutes outside of the target response time. However, once on scene, the Emergency Care Practitioner (ECP) was able to provide Mr Nute with the care and interventions required immediately. During this time he completed four sets of

observations, he cannulated, and administered IV morphine, 1 g paracetamol and 250 ml saline to Mr Nute. He completed most of the Patient Clinical Record, including the C-Spine assessment at 12:50 and recorded injuries (left hip) and mechanism of injury. In addition, he recorded the airway, breathing, circulation and disability (neurological) assessments. He has also completed a Major Trauma assessment, the conclusion of which was to convey to a Trauma Unit.

After conducting an initial assessment of the patient, the ECP made a request for priority 2 back-up at 12.40, after being on scene for 4 minutes. Regrettably, a DCA was not immediately available, as all resources were committed. The next available conveying resource was therefore allocated at 13.12 and arrived on scene at 13.44.

It is recognised by the Trust that waiting for a resource equipped to transport a patient to hospital for 2 hours would have been very distressing and uncomfortable for Mr Nute and for this we are truly sorry. However, it is important to bear in mind that ambulance services nation-wide are faced with resourcing difficulties and are required to send resources to the most time-critical patients as calls are received. It is important to remember that whilst it was not possible to convey Mr Nute to hospital as quickly as we would have liked, an ECP was on scene with him and providing him with essential care from 12.35.

As outlined in [redacted] report, at the time of the original call, activity was reported as being 20% above the predicted level, which consequently impacted on the availability of resources to attend.

In terms of the concerns received regarding a delay in conveying Mr Nute to hospital, a review of our systems has confirmed that the crew left scene at 14.55 and arrived at the Royal Cornwall Hospital Trust at 16.14, with a journey time of 1 hour and 20 minutes. I understand the crew encountered a couple of difficulties with the vehicle on the way to hospital which meant they had to stop on a couple of occasions for a few minutes. I am advised, however that the crew took the quickest route to the hospital which would ordinarily take 1 hour 5 minutes. This meant there was a delay to hospital but only by 15 minutes.

In terms of the question as to whether the call received was triaged appropriately, I can confirm that [redacted] investigation confirmed that the disposition reached for the original call was indeed correct. An audit of this call was undertaken as part of the investigation, which confirmed the call achieved 97% compliance against a pass rate of 86%.That said, it is acknowledged that the police were not notified of the incident until 12.56, an hour after the original call had been received. I am aware that concerns were raised during the inquest that the delay in notifying the police could have led to the driver of the vehicle leaving the scene and furthermore, placed a responsibility on those members of public on scene to effectively shield Mr Nute from passing traffic. It is acknowledged that a police presence may have also served to reassure both Mr Nute and the public that matters were in hand.

It is therefore accepted that the police should have been notified once it had been confirmed that there had been a road traffic collision, as per the Trust's Standard Operating Procedure, a copy of which is enclosed for your ease of reference. You will note that to ensure call handlers are able to focus on answering emergency calls, the responsibility for making the call rests with the dispatcher. It is, however, important that the requirement for police is made clear by the call handler when recording the details of the call on the screen, as this is the information used by the dispatcher to make decisions

regarding the allocation of resources etc. The need to call the police for assistance forms part of dispatcher's daily role and is one they are all acutely familiar with.

It appears the failure to inform the police in a timely way on his occasion could be attributed to human error. It is possible that this was, in part, due to a lapse communication but may also be due to how busy the service was that day. While it is not possible to identify a reason on this occasion, I wish to make it clear that as a service, we work alongside Devon and Cornwall Police on a daily basis and although problems will always be encountered due to the volume of calls received, on the whole we work together very effectively and maintain strong levels of communication.

In an attempt to ensure we work to continuously improve our working relationship with other emergency services, including Devon and Cornwall Police, representatives from the Trust attend a number of different meetings which provide a platform for any issues or concerns to be discussed and addressed. These include:

Emergency Services Forum

This is a meeting to discuss collaborative working and specifically how systems and processes can be improved.

Blue Light Collaboration

This is to discuss operational issues and pressures as well as future initiatives.

Frequent Caller Forum

This is a newly set up meeting to manage the above.

Blue light meeting

This is attended by a Trust representative to discuss issues and incidents that have been raised between the respective organisations with a view to agreeing how these might be addressed and resolved.

I can also advise that there is a Memorandum of Understanding between South Western Ambulance Service Foundation Trust (SWASFT) and the police services covering the same region which has been in place since 2013. The purpose of this document is to formalise the agreed working practices of those involved and seeks to underpin any localised arrangements already in place. Further, it sets out the expected level of service to be delivered by both SWASFT and the police at a local level.

In terms of what is being done to address the nation-wide resourcing difficulties faced by ambulance services, I can advise that in early 2015, Sir Bruce Keogh was asked to review NHS performance standards to ensure they make sense for patients and are operationally well-designed. This included those targets within the ambulance service, where in some cases, vehicles were being dispatched in order to "stop the clock" rather than serve the best interests of patients. This type of incentive was leading to the lower availability of ambulances for some urgent patients.

Since this review, NHS England has formed the Ambulance Response Programme (ARP) to conduct a clinically led and evidence-based review of the current call coding

systems. Professor Jonathan Benger, National Clinical Director for Urgent Care has led this work which aims to achieve three things:

1) Making sure our sickest patients get the fastest response. For example those in or near cardiac arrest get the nearest vehicle;

2) Where possible, to send the most appropriate vehicle to meet the patient's clinical needs first time e.g. stroke patients need a conveying double crewed ambulance rather than a rapid response car. This is because a key part of their care is to have a scan in hospital to see if they require thrombolysis.

3) Where clinically appropriate, look to increase the number of patients we treat, or signpost onto the correct service. In short, it's about improving the way we manage 999 calls to better meet the definitive clinical needs of the patients, rather than currently focusing on time targets.

ARP has now developed a new call coding set which has been trialling in two sites - South Western Ambulance Service NHS Foundation Trust and Yorkshire Ambulance Service for a minimum of 12 weeks since April 2016.

ARP is working with academic partners at Sheffield University's School of Health and Related Research (ScHARR) to oversee the process. The trial is monitored by an operational group chaired by the Association of Ambulance Chief Executives (AACE), reporting to the ARP Expert Reference Group and Steering Group. This work has also been shared with our national stakeholder group, including patient and public representatives.

I trust the above response addresses your concerns raised in your report in full but should you require any further information, please do not hesitate to contact me.

Yours sincerely,

Ken Wenman
Chief Executive