10th August 2016

Private & Confidential
Dr David Skipp
Assistant Coroner
Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

Dear Dr Skipp

Re: Inquest into the death of Valerie Margaret Ellis – 21 April 2016

Thank you for your letter regarding the concluded inquest into the death of Valerie Ellis. We write to you in response to the Regulation 28 report and the matters of concern points 3 and 4, being the only matters of concern which relate to IC24.

3) A disposition from 111 was made to IC24 for a telephone consultation by an on call clinician. This was received and logged and a call was made within one hour. There was no response by the carer and a note was made to call back within 5 minutes. Apparently the case was closed before this could occur; no explanation could be given as to why this happened. Training for clinician staff in the use of the computer system used by IC24 is essential but did not appear well organised and should be rectified.

IC24's own internal investigation found that the case was closed due to human error on the part of the GP concerned. The GP concerned could not explain why she had closed the case on the system and confirmed that training had been provided.

At the time of this incident the software version in use at the time had one warning box that appeared before a case could be closed and would leave the active case list. The prompt was "are you sure that no further action is required on this call, if not press save, if yes press complete"

As explained in evidence at the inquest in evidence by [redacted] since this case IC24 have introduced a new Failed Contact Guidance and a new software version which means that it is not possible to close a call before three attempts spread over the timeframes set out in the Guidance have been made. This change has improved the process and the software. All new users of the software are trained in this regard, and all established users have been informed of and reminded about the correct process.

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IC24 take the training of those providing its services very seriously.

At the inquest there was concern expressed by you regarding training on accessing information from the NHS Pathways NHS 111 report. The GP concerned did not appear to have the level of awareness regarding the accessing of the information from 111 that IC24 would have wished. Whilst there was no evidence that the failure to access the information from 111 had an impact on the outcome for Mrs Ellis, IC24 have reviewed the induction training programme and have specifically included the access of this information from NHS 111 pathway as a specific topic. A copy of the induction training programme is attached. IC24 have also sent in alert to existing out of hours GP reminding them about accessing this information.

4) The results of investigations by both KMSS and IC24 should result in a joint RCA. This has not occurred as yet and no date has apparently been arranged.

The SUI noted that there would be a joint RCA between KMSS and IC24.

A Joint meeting took place between IC24 and KMSS NHS 111 on 31 December 2015. At this meeting learning across the organisations was discussed and in particular Mrs Ellis case was reviewed. The note of that meeting is attached to this letter for your ease of reference.

[redacted] and [redacted] have discussed the merits of a further joint SI and RCA investigation. Given the joint working that has already occurred and that will continue, and the new processes regarding call closure instituted within IC24 and other actions taken they have concluded that a further RCA would not produce any new learning or actions.

If you would like any further details regarding these matters please do not hesitate to contact me.

Yours sincerely

Yvonne Taylor
Chief Executive

[redacted]
Medical Director

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