Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

[redacted]

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

[redacted]

31 March 2022

**PRIVATE & CONFIDENTIAL**
Mr Graham Hughes
HM Senior Coroner at South Wales Central
[redacted]

Dear Mr Hughes

**Sarah Marie Gilbert-Jones**

I write in response to the Prevention of Future Deaths Report issued to this Trust on the 4 February 2022, following the inquest in relation to Sarah Marie Gilbert-Jones.

I understand that, whilst giving evidence, my staff provided you with details of changes that the Trust has already made (since this incident), that would have affected how we respond to such a call received today. I will not repeat that information here, but rather build on those changes.

The issue of Propranolol overdose has already been discussed at the International Academies Of Emergency Dispatch (IAED) Clinical Focus Group, initially raised by another ambulance service. This is not an issue being faced here in Wales alone. One consideration has been as to whether there is a specific question set, with associated code group and priorities, which will identify the case as a propranolol overdose. The Medical Priority Dispatch System (MPDS) already has a question set that relates to Fentanyl which was an issue in some countries.

The issues of instigating different actions for different drug types are twofold. There is the fact that the individual drugs that can be involved in overdose cases are many and varied. Additionally, this moves away from the basis of the Trust's Clinical Response Model, where the sickest patients are identified and attended first. This Model is based on the patient's condition at the time and is not based on potential future changes to their conditions.

During the incident that was subject of the inquest, the floorwalker did upgrade the call to elicit a faster response, from an Amber 2 to an Amber 1. I wish to assure you that within the Standard Operating Procedure for the Clinical Support Desk, which allows clinicians to place a “flag” on an incident.

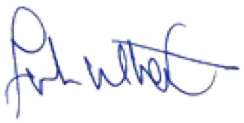
That flag identifies the case as an overdose of such things as Propranolol, and is visible for the staff responsible for dispatching vehicles. This flag indicates to the Allocator that a vehicle should be sent as soon as possible and that allows the dispatch teams to consider allocating available resources out of time order (as resources are normally dispatched to the highest priority/oldest call first).

I attach for your reference a plan that lists the actions the Trust is proposing to consider in order to address the issues highlighted within your Regulation 28 report. Any changes made will be included within the Trust’s Standard Operating Procedures (Clinical Contact Centre and Clinical Support Desk).

Whilst writing I would like to extend my sincere condolences to Miss Gilbert-Jones family on their sad loss. I am pleased to hear that they have accepted the Trust’s offer to reconsider this matter under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

I would also like to extend the offer to meet with you to discuss our response in more detail and to provide you with any further assurances you may require regarding our commitment to continuance improvement to support the prevention of future deaths.

Yours sincerely



[redacted]
**Chief Executive**

**Enc: Action Plan**