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BY EMAIL: [redacted]

M E Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Dear Mr Hassell

REGULATION 28 REPORT: ACTION TO PREVENT FUTURE DEATHS: TURAY-THOMAS

I am writing in response to the Regulation 28 report to prevent future deaths following the inquest into the death of Shanté Andreé Marie Turay-Thomas which you issued on 27th January 2020 to Anthony Marsh, Chair of the Association of Ambulance Chief Executives (AACE). We would like to clarify that Martin Flaherty is the Managing Director of AACE and is responding on behalf of Anthony Marsh and the Association. In addition, we have also liaised with both our National Medical Directors Group and NHSE.

To clarify, AACE is a private company owned by the English Ambulance NHS Trusts. It exists to provide ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. Our primary focus is the ongoing development of the English ambulance services and the improvement of patient care. We are a company owned by NHS organisations and possess the intellectual property rights of the JRCALC UK ambulance service clinical practice guidelines. AACE is not constituted to mandate or instruct ambulance service however we do have national influence via the regular meetings of ambulance Chief Executives and Trust Chairs along with a network of national specialist sub-groups.

I have read and considered your report. Although no specific action was requested of AACE the observations within section 16 of your report are those about which I can offer comment.

In line with the evidence you heard, at the time of this incident there was an inconsistency in the way in which AMPDS and NHS Pathways categorised anaphylactic shock. Whilst the technicalities of how the respective triage systems operate would be more appropriately commented on by others, it is worth noting that the tools have fundamentally different architecture and methods of operation. They are always likely to produce differing outcomes however we have worked closely with NHS England and other partners to reduce the variation as far as possible.

Specifically, in relation to anaphylactic shock we have previously made representation to NHS England through the now disbanded Ambulance Response Programme Delivery Group (ARP DG)

and the Emergency Call Prioritisation Advisory Group (ECPAG) requesting that the clinical coding inconsistency between AMPDS and NHS Pathways should be resolved as a matter of urgency. ECPAG is the NHS England led group responsible for the governance, control and approval of any change to clinical code sets (aligning codes to response categories). NHS England subsequently tasked the Clinical Coding Group (a sub-group of ECPAG administered by NHS England) to resolve the inconsistency. As you heard through evidence submitted to you at the inquest, the inconsistency was resolved, and NHS Pathways now has a route through which severe and sudden onset anaphylaxis is categorised as a Cat 1 response.

Your report makes the observation that inconsistency may remain in parts of the country where NHS Pathways is in use by the 111 provider and AMPDS is in use by the ambulance trust. I do not believe that is the case and, having consulted with clinical and operational colleagues within AACE, I cannot conceive of a circumstance where an incidence of anaphylaxis would be categorised as Cat 1 by the 111 provider but result in a different categorisation by the ambulance trust. Once categorised by 111 incidents are passed directly to the Computer Aided Dispatch (CAD) system of the ambulance trust bypassing any further call handling or other intervention. The incident would present as a Cat 1 to the ambulance despatcher who would allocate an ambulance response.

Therefore, your subsequent observation that 999 call handlers should ‘safety net’ the 111 triage is I think answered by my clarification that the remaining inconsistency that you believed there to be between 111/999 system does not in fact exist in relation to anaphylaxis. More generally it is true to say that, as a matter of NHS England policy, 999 call handlers do not routinely re-triage (or ‘safety net’) triage conducted by 111. This policy was introduced through the Ambulance Response Programme (ARP) governance in order to ensure that patients originating in 111 did not end up in a repetitive ‘triage loop’ which would disadvantage them through delaying the dispatch of an ambulance resource. Ambulance trusts agreed with NHS England that this would be inappropriate and that 111 triage should be accepted as a given with incidents deemed as requiring an ambulance response being placed directly in the 999-dispatch system by 111.

Incidents originating either in 999 or 111 may be subject to additional clinical assessment by clinicians in ambulance control rooms but this would be conducted on the merits of the incident irrespective of the origin of the call. This would typically be conducted where an ambulance service has a queue of incidents that are awaiting an ambulance to become available to dispatch. In those circumstances clinicians may review the queue of incidents to judge whether any may be suitable for clinical telephone assessment or to establish further information about the patient’s condition which in some cases may result in the category of the incident being changed. Although it is possible that Cat 1 incidents could be subjected to additional clinical assessment, the speed of dispatch to Cat 1 incidents means that it is very unlikely to happen in practice.

I trust you will accept that I have considered your report carefully and have addressed those issues which I am able to and particularly those articulated in Item 16.

Yours sincerely

Martin Flaherty OBE
Managing Director