IAED | International Academies of Emergency Dispatch.

International Academies of Emergency Dispatch
& Priority Dispatch Corp UK Ltd
Spectrum
Bond Street
Bristol
BS1 3LG

The Coroner's Office for the County of Dorset
Civic Centre
Bourne Avenue
Bournemouth
BH2 6DY
United Kingdom

22th May 2023

Dear Sirs

RE: Response
Regulation 28 Report to Prevent Future Deaths – Kenneth Michael Adams

Pursuant to the Coroner's Report received 29th March 2023 ([redacted]), the International Academies of Emergency Dispatch encloses its response to the report.

I wish to express my gratitude to your staff who assisted us by obtaining the necessary documentation from the South Western Ambulance Service NHS Foundation Trust, enabling the Academies to fulfill its due diligence to thoroughly review the case and respond accordingly.

I wish also to thank you for agreeing to extend the deadline date while all the documentation was collected.

If there are questions, or a follow-up is necessary please do not hesitate to contact me.

Yours Sincerely,

[redacted]

Priority Dispatch
Project Coordinator Lead
[redacted]

Summary:
There were several compounding factors that contributed to the delayed EMS response in this case. First and foremost, the nearly eight-hour response is far beyond the CAT 3 standard assigned, and beyond any clinical or public expectation known to this reviewer.

The SERIOUS Haemorrhage code suggested in the coroner's report is equivalent to the initial code assigned with regard to CAT 3.

EMDs are trained to stay on the line while providing Dispatch Life Support instructions like bleeding control. This may have helped to stop the bleeding in this case, or at least alert the same EMD to the persistence of the bleeding. Instead, repeated calls to various EMDs from Careline, whose personnel were not at the scene, resulted only in inquiries about the patient's condition worsening, and the callers simply did not have this information.

In times of high call volume, SWAST EMDs are instructed by local policy to provide Dispatch Life Support instructions and then utilize the Urgent Disconnect option in ProQA to end the call. This policy and practice does not ensure the instructions are carried out and does not allow for essential monitoring of conditions such as active bleeding.

There was no productive follow-up to Careline's 3rd call to 999 after learning the patient's condition had apparently worsened. A voicemail was left at the patient's residence at 0806, but no other known action was taken. No ProQA Summary record was received for Careline's 2nd or 3rd call and there is no record of re-triage other than asking the 4th party caller if the patient's condition had worsened. This leaves significant gaps without a proper re triage between the 1st and 4th calls (3hrs 44 min), and the 4th and 6th call (3hrs 45 min).

A 4th call from Careline was received at approximately 1030 and the EMD was advised the patient was still bleeding, but an ambulance was still not dispatched until 1143 when a 2nd party caller from the residence advised the patient was not alert. A CAT 2 response was then assigned.

Recommended Actions:

1. The IAED is currently implementing new language designed to better define the term SERIOUS Haemorrhage and structure the related Key Question in a way that persistent, uncontrolled bleeding is more definitively qualified as SERIOUS Haemorrhage. It is recommended that UK Ambulance Trusts educate EMDs that uncontrolled bleeding should be considered SERIOUS Haemorrhage until proven otherwise.
2. SWAST SOP VH45 v.2.1, *MPDS Case Exit and use of Urgent Disconnect*, Section 3.4 or 3.5 should be immediately amended to include uncontrolled bleeding and potentially 1st Party alone patients as exceptions, and EMDs should be educated and encouraged to continually provide bleeding control instructions until bleeding control is achieved or responders arrive. Bleeding that persists after bleeding control instructions have been provided requires active management.
3. Repeat calls for assistance from a caller not on scene with the patient should be followed

up in a manner that ensures complete and accurate updates are received and instructions are carried out. EMDs should be encouraged to request 3rd or 4th party caregivers to make their way to the scene to conduct a proper, 2nd party re triage, closely monitor 1st-party-alone patients, and carry out any instructions provided. Asking a 3rd or 4th party caller if the patient's condition has worsened should not, in and of itself, be considered an accurate or complete re-triage.

4. The IAED is currently studying the potential impact of the unique coding of patients who are taking anticoagulant/antiplatelet medication (blood thinners) who have active bleeding or closed head injuries. Due to the relatively high number of patients receiving this therapy* as compared to the number of patients who are at risk of a poor outcome related to that therapy, there is significant risk of over-triage, which may only make matters worse in areas with limited resources. Another consideration is that those patients who do not meet these criteria will inevitably suffer even longer wait times as a result. *Preliminary data suggests that nearly 22 percent of all patients with a chief complaint of hemorrhage are on blood thinners (30 percent of those aged 60-75 and 41 percent aged 75-90).

Commentary:

There are inherent risks associated with exceptionally long response times, no matter what the Chief Complaint may be. A patient appearing stable at the time of the first call may develop problems not associated with the Chief Complaint and such problems may be missed even when reassessed as those issues may not be apparent. All-to-common examples are complications of prolonged immobility or adverse environment or, as in this case, the inability of lone patients to accurately assess a problem or carry out basic instructions. And as additional codes are requested to prioritise patients at greater risk, with the dangerous assumption that the others can safely wait for extended and indefinite periods of time, more and more apparently stable patients are subject to developing additional problems associated with comorbidities or environment. It is apparent that an impactful lack of resources, rather than triage inefficiencies, is primarily responsible for these prolonged response times and, until this fundamental problem is appropriately addressed, patients will continue to suffer the consequences.

[redacted]

[redacted]

Chair, Medical Council of Standards, IAED Academy Protocol Development

IAED International Academies of Emergency Dispatch.