NHS
East of England Ambulance Service
NHS Trust

East of England Ambulance Service NHS Trust
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

HM Coroner Sean Cummings
Assistant Coroner for Bedfordshire and Luton
By email

5 March 2024

Dear Mr Cummings

I am writing further to the inquest into the death of Lucas Pollard, which concluded on 18 January 2024. I understand that a number of EEAST staff gave evidence in relation to the Serious Incident investigation that took place.

Following the inquest, you made a Regulation 28 Preventing Future Death report on 1 February 2024 outlining your concerns in relation to the dispatch arrangements of the critical care team; the rigid application of the End of Shift Policy without evidence of an ongoing reassessment of the situation; and that the deterioration of Lucas did not lead to a further review of the call. I have outlined the actions we are taking in relation to each of these aspects below:

A Critical Care Team was not dispatched immediately and there was likely a lack of clinical information for some considerable time, whilst waiting for the land ambulance to arrive.

Generally, if the journey time for the Critical Care Team to arrive with a patient exceeds 45 minutes, they may not be immediately dispatched as the land crew may arrive and decide to leave scene immediately. Other factors that influence dispatch decisions at any given time include competing calls requiring further interrogation and triage that may also require higher levels of care and regional availability.

The integration of the Critical Care desk function from a two-person team into all three control rooms will significantly enhance EEAST's ability to identify, continually monitor and reassess need for enhanced care. We will also share a case study of our attendance to Lucas with the Critical Care Desk clinicians for awareness.

The End of Shift Policy was applied without evidence of an ongoing reassessment of the situation and the Rapid Response Vehicle was not deployed.

The End of Shift Policy currently states that "in the event of a call where there is a significant clinical patient concern, this should be immediately reviewed by a Clinical Coordinator and/or a Senior Ambulance Operations Centre (AOC) Clinician. If either the Clinical Coordinator or Senior AOC Clinician deems it necessary, they have the ability and authority to authorise an override of

the last 30 minutes and dispatch the nearest available resource". Unfortunately, the escalation to the Clinical Coordinator or Senior AOC Clinician did not happen on this occasion. The End of Shift Policy is currently being reviewed in order to ensure it remains clinically appropriate for our patients' needs but also meets our obligations in relation to staff welfare. Once the policy has been reviewed and approved, it will be shared with all AOC staff and included in any update training. We aim to complete this piece of work by the end of June 2024.

There was clear evidence from the 999 calls and the obvious deterioration of Lucas from sounds in the background but that did not prompt a review of the call.

There were opportunities to escalate this call to the Clinical Coordinator or Senior AOC Clinician for further review. Active listening and escalation of calls are covered throughout the Call Handlers' training course, with specific emphasis on the type of calls that should be escalated. An article will be published in What's Out Wednesday, which is the weekly newsletter shared with all AOC staff across the Trust, for general awareness in order to remind staff of the importance of active listening and escalating calls where appropriate. In addition, it will be picked up specifically with the call handlers in their supervision/1:1 meetings.

I am happy to provide you with a further update once these actions have been completed. Please do not hesitate to contact me should you require any further information in the meantime.

Yours sincerely,

[redacted]

[redacted]
Chief Executive