South East Coast Ambulance Service NHS
NHS Foundation Trust

South East Coast Ambulance Service
NHS Foundation Trust
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Mrs V Hamilton-Deeley
HM Senior Coroner for Brighton and Hove
The Coroner's office
Woodvale
Lewes Road
Brighton
BN2 3QB

30 April 2018

Dear Madam

[redacted]

Re: Mr Kevan FUNNELL – response to Regulation 28 report

Thank you for your letter of 27 February and attachments.

I am very sorry that the care provided to Mr Funnell fell below the standards we strive to achieve. I have carried out an investigation into the concerns you have raised and set out my findings below.

Following your Inquest, we arranged a second audit of the original 999 call. This was found to be non-compliant. One of our senior auditors, a registered Paramedic, has reviewed this call and believes that the consciousness level of Mr Funnell could be judged differently by the description provided, and so this is likely to be why the two audits reached different conclusions. As a clinician, she would have probed further to clarify the precise level of consciousness.

The second call (at 2354 on 22.10.17 and not at 0016 on 23.10.17 as previously thought) has also been audited. This call was taken by the same call taker as the first and was also found to be non-compliant on the basis that the call taker should have probed further regarding Mr Funnell's bleeding, temperature and level of consciousness. The findings of both audits have been fed back to the person concerned for individual reflection and learning.

I can confirm that there are adequate provisions in place, which provide for call takers to upgrade a call where the patient is in an unsafe public place (including when this relates to weather conditions) and to seek advice if they are concerned about the disposition reached.

For Mr Funnell, the call taker did not seek to upgrade the call. This was human error. The manager of the Emergency Operations Centre (EOC) has used the learning from this case to remind all call takers about the circumstances to consider when upgrading a call and the need to seek senior guidance if there is any doubt about the disposition reached through NHS Pathways.

As I believe you are aware, NHS Pathways is a national triage system used by half of the ambulance services in England. It is under constant review and direction by the National Clinical Governance Group, which comprises NHS clinicians with extensive experience in the urgent and emergency care services.

On 22 November 2017, we implemented a significant update to NHS Pathways. The new version includes amendments to the supporting information for conscious patients, in order to try and make it more robust and easier for call takers in situations like this one, to identify consciousness levels. If this updated version had been in use in October 2017 then Mr Funnell would have been classified as unconscious. The disposition would therefore have most likely been a Red 2 response with a target attendance time of 8 minutes. This demonstrates the evolving nature of the Pathways system.

In March 2018, there was a meeting between NHS Pathways and the ambulance trusts who use the system. NHS Pathways requested that all reports made by a Coroner, in which concern is raised about the use and application of NHS Pathways, are shared with them so that any recurring issues and trends can be identified and action taken.

In your report, you raise concern about the delay in the ambulance attending. I can confirm that on 22 and 23 October 2017, we were experiencing delays in handing over patients to both the Royal Sussex County Hospital in Brighton and the Eastbourne District General Hospital. Hospital handover delays has a very significant adverse impact on our ability to respond to patients waiting for an ambulance. This is a national issue and in our region one that has more recently been given much focus by the entire healthcare system. We are starting to see some improvement but back in October 2017 thousands of hours were lost due A&E departments being unable to accept timely handover of patients from our crews.

In addition, the demand for our services on the night in question was greater than had been forecast. Since then, there has been much improvement in how we forecast and during 2018 the ambulance and crew hours we have available much more closely match the level of demand.

To summarise, it is clear that there was an error with the original classification of Mr Funnell and then a failure to upgrade his call. For this, I am sorry. Although this was human error, the recent NHS Pathways upgrade will significantly reduce the risk of such an error recurring. We are currently working with our commissioners in a jointly commissioned demand and capacity review, intended to better align our resource requirements to the demands on our service, particularly in the light of the newly introduced Ambulance Response Programme standards.

I do hope this information is helpful and if I can assist you further, please do not hesitate to contact me.

Yours sincerely

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[redacted]
Chief Executive
South East Coast Ambulance Service NHS Foundation Trust