VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC..
GILVA D.J.TISSHAW, BA(LAW)HONS

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	THIS REPORT IS BEING SENT TO: 1. [redacted], **Head of Legal Service, South East Coast Ambulance Service** 2. [redacted], **Emergency Operations Centre Manager, South East Coast Ambulance Service** 3. [redacted], **Chief Executive, South East Coast Ambulance Service**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On **10th November 2017** I commenced an investigation into the death of **Kevan FUNNELL**. The investigation concluded at the end of the inquest on**14th February 2018** .The conclusion of the inquest was **ACCIDENT**
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: –

VERONICA HAMILTON-DEELEY DL, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC...
GILVA D.J.TISSHAW, BA(LAW)HONS

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

At the Inquest into the death of Mr Funnell I heard that the ambulance have introduced a relatively new system of dealing with calls and it seems to me timely to write now because it was a matter of concern to me that the ambulance was so delayed in its response to Mr Funnell.

You will be able to see the basic facts in Part 3 of the Record of Inquest.

This was an older man with an obvious head injury lying in the public highway on a freezing cold night.

The first call was at 23:36 and was apparently graded with a 30 minute response (I know that 30 minute responses do not exist now but they did at the time that we are talking about i.e. in October 2017).

If the ambulance had arrived within the 30 minute response time it would have been at the scene by no later ten past midnight.

At 16 minutes past midnight there was a second call, firstly to ask where the ambulance was and secondly to explain that Mr Funnell was now vomiting and there was blood in his vomit. This was not flagged up and I was told at the Inquest that if it had been, it would have upgraded the call. Therefore, following Call 2 there was no change in status, the caller was told to ring again if things got worse, an apology was given but there was no estimated time of arrival.

Call 3 came in at 00:34 hours, i.e. 58 minutes after the first call to say that the patient was now unconscious. This call was upgraded to what was a Red 1then and what I understand would be a C1 now. That is to say it was upgraded to an 8 minute response from 00:34 so the ambulance should have been there by 00:42 and in fact an ambulance arrived at 00:51.

This is really a shocking performance.

Apparently there has been an audit and Cal 1 passed the audit; I cannot think why. There was no inability to triage the call but no-one was assigned so effectively that call was abandoned.

With regard to Call 2. Effectively Call 2 was also abandoned.

Your Legal Advisor at the Inquest took issue with my using the term "abandoned" however, it seems to me that that is exactly what happened and if there had not been a third call (all these calls were made by complete strangers to Mr Funnell who just found him lying in the road as they were coming and going about their

VERONICA HAMILTON-DEELEY DL, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC...
GILVA D.J.TISSHAW, BA(LAW)HONS

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

	business; it was they who took care of him, accepted responsibility for him, tried to keep him warm, tried to keep him comfortable, tried to keep him safe and they should be able to rely on a good ambulance response in those circumstances) it seems possible that he might have been left in the street for maybe another hour at least. I was told that the only way you can interrupt the system is by flagging up the need for a clinician. If that is not done, [redacted] explained that during each shift a clinician will look at the stacked calls and will call back and make a decision about whether or not to upgrade the call. I was told that the fundamental problem was that the original triage was probably wrong and in any event there were no 30 minute responders available at that time. I was also told that the call taker can always use their initiative and ask a Clinician to come and intervene and advise them. [redacted] agreed that it would be useful if there was more training for the call takers so that they did not feel inhibited from involving the clinicians in potentially difficult calls. During the course of my summing up I expressed the view that for Mr Funnell in this particular case, the Pathway system that SECAMB uses was not fit for purpose and in any event seems unsuited, without modification, to an emergency service.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **21st May 2018**. I, the coroner may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC..
GILVA D.J.TISSHAW, BA(LAW)HONS

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

	1. [redacted] 2. Brighton and Hove Clinical Commissioning Group, 3. Care Quality Commission, 4. Secretary of State for Health, Department of Health 5. [redacted], Chief Executive, NHS England I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Date: 27th February 2018 SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**