West Midlands Ambulance Service
University NHS Foundation Trust

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Mr Bennett
Area Coroner for Birmingham and Solihull
50 Newton Street
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17 July 2024

Dear Mr Bennett

Re: Robert John Fray

Thank you for your email dated 6 June 2024 attaching your Regulation 28 Report.

Firstly, I am sorry that you have had to raise concerns with West Midlands Ambulance Service University NHS Foundation Trust (WMAS) following the inquest of Mr Fray. Can I please take this opportunirty to pass on my sincere condolences to the family of Mr Fray. I have addressed the specific concerns raised in the regulation 28 report below. Following a full review of the case I also wish to take the opportuntiy to make some additional observations and additional clarity around the sequence of events.

Please see our response to your concerns.

Concern 1

A volume of 999 calls over a longitudinal period (vs a volume of calls in a short space of time) does not trigger or prompt NHS Pathways to require the call assessor to consider whether a more urgent response is needed. The simple fact of repeated 999 calls over a longitudinal period may be an indicator of a worsening situation. Currently, the call assessor repeats at each call the question 'has the presentation changed?' and is reliant on the judgment of the caller who may not have the complete picture (e.g. Mr Fray's neighbour), rather than also having regard to the number of calls.

Response

The Trust answers, triages and processes 999 calls in-line with established call taking protocols that detail the required actions for managing duplicate or repeat calls. Most duplicate calls received are not because a patient's condition has changed, they are because a caller is seeking an estimated arrival time. These calls are not routinely retriaged as it has been confirmed that there is no change in the patients presenting condition which means that the response category will not differ from that originally established. All duplicate calls from patients or callers, where it is confirmed the condition of the patient has changed or worsened will receive a full NHS Pathways triage. If the

triage has resulted in a higher category of call, then the new category becomes the required response to the patient.

As described in the circumstances relating to the Regulation 28 Report to Prevent Future Deaths, during the fifth 999 call that originated from a neighbour, Mr Fray received a further triage of his symptoms requiring a category 2 response. A higher response category would not have been achieved, due to Mr Fray being reported as conscious and breathing regularly. This call would therefore not have changed the priority of the existing response.

The Trust does acknowledge that the final call from the neighbour was not identified as a duplicate call for Mr Fray and was therefore not linked to the original calls. This resulted in an ambulance responding to the location of the initial call, creating a further delay to Mr Fray. Contact was made with Mr Fray and the ambulance subsequently responded to his home address.

I wish to convey my apologies to Mr Fray's family, as this further delayed the response by 14 minutes.

The Trust acknowledges the concern raised in Regulation 28 Report to Prevent Future Deaths, relating to the management of repeat calls. The Trust details the actions to identify duplicate, or repeat calls, in response to concern 2 below. In response to your first recommendation, the Trust will implement a change in call taking protocol that requires a clinical review of a patient's condition where three or more repeat calls are identified. This will support an immediate review of the patient's call history and presenting symptoms.

Concern 2

Linked, the automated 'duplicate checker' is based on checking location within a 250-meter radius and not the patient's name. As Mr Fray had moved more than 250 meters between 999 call no.3 and 999 call no.4, the call at 23:05hrs was not identified as a fourth call. It follows the call assessor was not prompted to ask whether his presentation had worsened and the ambulance was sent to an out-of-date location. This would not have happened had the 'duplicate checker' included Mr Fray's name rather than simply looking for a location within 250-meters.

Response

The Trust has two methods for identifying potential duplicate or repeat 999 calls for the same incident. The first is the 'duplicate checker', referred to above which identifies cases received in the previous 3 hours, within a 250-meter radius and up to 30 minutes after the case is closed. The intention of the duplicate checker is to identify multiple calls that may relate to the same incident, for example, multiple calls for an incident on a motorway. The second method is the 'Call Location History Checker' which will recognise and record when three or more 999 calls have been received to an exact location, over a 24-hour period.

The Trust is sorry that in the case of Mr Fray neither method described correctly identified the final call to his home address as a duplicate call. The Trust therefore agrees with the recommendation within the Regulation 28 Report to Prevent Future Deaths to implement an alternative method for detection based upon the patient's personal demographics.

A formal development request and specification has been submitted to our Computer Aided Dispatch (CAD) system provider, Cleric Computer Services. The development details identification of repeat calls based upon personal demographics; to include, the patient's name, date of birth, NHS number, and the patient's or caller's telephone number. This is therefore not limited to the current location and radius settings within the existing methods described.

Cleric Computer Services have acknowledged the development request and confirmed feasibility to deliver the requirements. The Trust does not have a date for implementation due to the technical work required; however, Cleric have acknowledged the associated Regulation 28 Report to Prevent Future Deaths and the necessity to implement promptly.

Additional Observations

In total there were four calls received from the Kidney Treatment Centre (not three as suggested in the PFD) as detailed below, all of which were calls made by clinical members of staff from the centre. Please note that the time of calls listed below are electronic time stamps from within the Trusts computer systems and accurately reflect when the calls were answered by the ambulance service.

The first call was received at 18:03 hours and, based upon the information provided by the clinician the call was correctly coded as a category 3 incident. At the time of this call West Midlands Ambulance Service was under significant pressure with 629 unallocated emergency calls awaiting a response, 209 of which were in Birmingham.

The second call was received at 19:32 hours. The clinician making the call confirmed that he was calling to chase an estimated time of arrival (ETA) for the ambulance and did state that there had been no deterioration in the patient's condition. However, the call assessor prompted the caller, asking if he felt that a high priority was required and also asked directly if he thought that the patient may be suffering from sepsis. To this end the call was correctly categorised as a Category 2 incident. There were still no ambulances available to respond as there were 529 emergency incidents outstanding, 216 of these were category 2 incidents, 97 of which were in Birmingham.

A third call was received at 21:18 hours where the clinician making the call confirmed that the patient's condition had not changed and that he was requesting an estimated arrival time of the ambulance. The call assessor correctly informed that the Trust was extremely busy at the moment and that she was unable to provide a timeframe and advised that if Mr Frays condition did deteriorate then please call back. As the patient's condition had not changed the category 2 response remained.

A fourth and final call from the treatment centre was made at 22:17 hours where it was confirmed that Mr Frays condition had not worsened but they were calling to see when an ambulance may arrive as the centre would be closing soon. The call taker was unable to provide a specific time frame for a response but did confirm that Mr Fray was a high priority call and that as soon as an ambulance was available to respond then it would. During this call there was no mention that Mr Fray would be going home.

A fifth call in relation to Mr Fray was received at 23:05 hours. This call was made by one of Mr Frays neighbours who confirmed he had just returned from dialysis and that he had been informed that he had an infection. Mr Fray had just got back and not made it into the house yet as he was being sick and shaking. The call taker correctly asked to speak to Mr Fray who tried to speak to the call taker but found this difficult, so the phone was handed back to the neighbour. The neighbour confirmed that the treatment centre did want to send him to the hospital, but Mr Fray did not want to go. The call was correctly categorised as category 2 and was recorded as a new case because it was a new location and there was no indication that a call already existed in the system for Mr Fray, and there was no mention that Mr Fray was already waiting for an ambulance response during the call.

When listening to all four calls that originated from the treatment centre as listed above there was never a mention of Mr Fray leaving the centre and returning to his home address. This is why the ambulance crew that did eventually become available to respond to Mr Fray firstly went to the Kidney Treatment Centre as this was still a live incident and had been waiting the longest. When the crew arrived at the centre to find it was closed,

they contacted the EOC who in turn contacted Mr Fray directly where it was identified that he was now at his home address. The location for the incident that the crew were already tasked to was amended and the crew arrived with Mr Fray at midnight and provided treatment and onward conveyance to the Queen Elizabeth hospital, they arrived at 00:59 hours.

On this day in question the Trust was under a great deal of pressure, not specifically because of increase demand but due to the significant and consistent hospital handover delays which meant that over 1,756 operational hours were lost due to extensive hospital handover delays. To put this into perspective it equates to losing 25% of the staff on duty for the day. The Target for hospital handovers is 15 minutes, the 1756 lost hours is in excess of the 15-minute handover target.

The Trust prides itself on having the very best response times and for the clinical excellence offered to patients and service users however the lost hours seen on this day, due to hospital handover delays, significantly impacted on the Trusts ability to respond in a timely manner.

I wish to convey my personal condolences and sincere apology to Mr Fray's family for the time taken to respond an ambulance to Mr Fray following the initial call from the dialysis centre and for the further delay whilst responding from the kidney treatment centre to Mr Fray's home address.

Please do not hesitate to contact the Trust if you require any further information.

Your sincerely

[redacted]

IEUC & Performance Director

Cc: [redacted]