ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Association of Ambulance Chief Executives
25 Farringdon Street
London
EC4A 4AB

20 August 2025

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Debbie Rookes
Assistant Coroner for the Coroner Area of Avon

Dear Ms Rookes

DAVID STEWART GIFFORD (DECEASED)

I am writing in response to the preventing future deaths report issued to our executive officer at the Association of Ambulance Chief Executives (AACE), and I respond as our Director of Operational Development and Quality Improvement on behalf of AACE.

On behalf of AACE, I would like to extend our sincere condolences to the family of Mr Gifford.

It may be helpful for us to explain that AACE is a private company owned by the English and Welsh ambulance NHS trusts. It exists to provide ambulance services with a central organisation that supports, co-ordinates and implements nationally agreed policy. Our primary focus is the ongoing development of the English ambulance services and the improvement of patient care. It is a company owned by NHS organisations and possesses the intellectual property rights of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) UK ambulance service clinical practice guidelines (the "JRCALC guidelines"). AACE is not constituted to mandate or instruct ambulance services, however, it has national influence via the regular meetings of ambulance chief executives and trust chairs, along with a network of national specialist sub-groups.

We respond in relation to your matter of concern (1):

> *Training and knowledge focuses on the classic signs and symptoms associated with an AAA. However, there are a group of patients who will not present in this way, and who may be challenging to diagnose. Whilst there may be many medical conditions that could be similar, there does not seem to be much focus given to the identification of vascular emergencies within training and knowledge updates. Therefore, when paramedics attend emergencies, in the absence of classic symptoms, they may be wrongly reassured. Where a person has an extensive aortic history, the importance of aortic pathology should be considered.*

AACE are not responsible for the training or education of ambulance staff, however we plan to share and discuss this preventing future death report with ambulance service medical directors (NASMeD) at our next national meeting. We will recommend that NASMeD consider if any further education or awareness raising regarding vascular emergencies including aortic aneurysms is required. We will

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also share the PFD report with the education leads of ambulance trusts, via the national education network for ambulance trusts (NENAS).

Regarding your second matter of concern (2):

> *There has not been training or medical education for ambulance on vascular emergencies for a long time. The evidence was that JRCALC guidelines did recently highlight the number of patients that may not present with the traditional 'red flags' but did not provide further guidance. This is a national issue where ambulance staff should be knowledgeable about the more subtle signs of vascular emergencies that may be missed.*

The JRCALC guidelines are advisory and have been developed to assist paramedics to make decisions about the management of the patient's health, including treatments and to support clinical practice. The advice is intended to support the decision-making process and is not a substitute for sound clinical judgement. We recognise that the guidelines cannot always contain all the information necessary for determining appropriate care and cannot address all individual situations; therefore, we expect that paramedics using JRCALC guidelines ensure they have the appropriate knowledge and skills to enable suitable interpretation.

We discussed your matters of concerns at our JRCALC meeting on the 22 July 2025. JRCALC consists of expert medical advisors including those with vascular and surgical knowledge. The committee made the decision to undertake a review of the existing abdominal pain and vascular emergencies guidelines. We will look to include additional terminology for clinicians to ensure that they take account of the potential for patients with extensive aortic history not to present with traditional red flag symptoms and to carefully consider whether they should be transported to hospital. We will also advocate the use of the Aortic Dissection Detection risk score during their clinical assessment to aid decision-making around conveyance. Finally, we will also include reference to the potential for 'Endoleaks' following an aortic repair.

We will follow our existing process for the review and update of our guidance, and this is expected to take around three months. Once complete, the revised guidelines will go for approval at the JRCALC committee, and then for final ratification at the national ambulance services medical directors' group (NASMeD). New and updated guidelines are released onto the JRCALC App at regular intervals throughout the year. Ambulance trusts, via senior clinicians, are given at least four weeks' notice of planned updates so that they can prepare for the updates and consider any local education that may be required to support new guidance.

If you have any further questions, please do not hesitate to contact me.

Yours sincerely

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Director of Operational Development and Quality Improvement

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