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Mrs Selena Lynch
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St Pancras Coroner's Court
Camley Street
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27 February 2014

Dear Mrs Lynch

Coroner's Prevention of Future Deaths report - Barnabas Newlyn

I write in reply to your Regulation 28 report to prevent future deaths sent to Sir Bruce Keogh, Medical Director of NHS England, subsequent to the inquest into the death of Barnabas Newlyn on 6 November 2013. Your matters of concern listed "particular difficulties in arranging timely transfer" though you noted that "earlier transfer would have been unlikely to affect the outcome". The Court was concerned that even without delay the time taken for a road journey from Margate to Great Ormond Street may well damage the future prospects of a patient needing time sensitive critical care transfer and in particular neurosurgical emergencies. You noted that it may be necessary to consider air transfer for such cases.

I received your letter on 14 January 2014 for action and subsequently agreed an extension to the end of February 2014 to formulate a reply. In this time I have assembled evidence principally in the form of root cause analyses of the incident from agencies involved and have considered the issues raised with the senior membership of those organisations including the Medical Directors of South East Coast Ambulance, and East Kent Hospitals University Foundation Trust, Accountable Officers of the Thanet and the Dartford, Gravesham and Swanley Clinical Commissioning Groups (the latter being the lead commissioner for South East Coast Ambulance Service), the Head of Specialist Commissioning for Kent, Surrey and Sussex, and the lead officer for the Operational Delivery Network for Critical Care in the Region.

To summarise the timings involved which were of critical significance in the case: BN arrived at QEQM Hospital in Margate at 1232, QEQM critical care staff contacted South East Coast Ambulance at 1615, the ambulance arrived at 1715, and the patient arrived at Great Ormond Street Hospital at 1832.

There are two relevant root cause analyses in this case. The first was provided by East Kent Hospitals University Foundation Trust. This noted that a neurosurgical emergency is a rare event for a district general hospital. Indeed it is the South East Coast (SECAMB) Medical Director estimates that there is approximately one neurosurgical emergency of this nature in their operational area, which extends across Kent, Surrey and Sussex, per month. The time interval between arrival at hospital and the contacting of SECAMB is noted. The RCA itself notes that there was difficulty in contacting SECAMB which is a matter of record. However readiness for transfer was also affected by a lack of appropriate equipment at the hospital itself; in this case the lack of an appropriate connection for the portable paediatric ventilation unit. SECAMB have also conducted an RCA: this notes there were significant resource issues in the East Kent locality that Saturday afternoon (which means that there were gaps in the on call rota for ambulance crews and thus less units on the road than planned), secondly there was “poor resource utilisation” meaning that the selection and prioritisation of available ambulance units for the transfer from QEQM to Great Ormond Street left room for improvement. This is also a matter of record and has been fully analysed by SECAMB. The SECAMB Medical Director also noted that there is a protocol for care in operation which states that when two calls of equivalent urgency are received at the same time (as was the case on this occasion) the priority goes to the patient who is not in receipt of care (in this case a patient with symptoms compatible with a heart attack). It was noted that this protocol may in certain exceptional circumstances need to be revisited, although the principle in itself it is reasonable. Finally it was noted that a non-paramedic crewed vehicle would have been suitable in this case though a paramedic crew was requested. This would be acceptable because the patient will be accompanied by a critical care trained doctor and nurse on transfer between hospitals and thus paramedics are not required. An ambulance would have been available earlier had this been the case.

There is also guidance on the subject of neurosurgical transfer from a joint statement of the British Society of Neurological Surgeons and the Royal College of Anaesthetists. The guidance states that “most children with life threatening neurosurgical conditions will come to more harm from the delay related to the time waiting for a paediatric intensive care retrieval team to travel to the referring hospital than from the relative risks of a direct transfer by the non-specialist hospital transfer team”. Therefore guidance states that “transfers of children for emergency neurosurgery should normally be undertaken by the referring hospital” and that “very rarely the use of retrieval teams may be appropriate”. The guidance does not deal with the issue of air ambulance transfer outside of these principles.

The reorganisation of the NHS from April 2013 has led to a change in commissioning arrangements and in particular a reorganisation of networks and relationships which have taken time to settle. Nonetheless commissioning mechanisms do exist within NHS London, the Paediatric Neuroscience Clinical Reference Group of NHS England (national), local specialised commissioning resources, and the Major Trauma Operational Delivery Network for South London and Kent, with which a longer term solution can be pursued.

The availability of an air ambulance resource was discussed in some detail. The NHS in Kent, Surrey and Sussex does have access to an air ambulance service and recently that service has received clearance to fly outside the hours of daylight. It was noted however that there are difficulties in building the air ambulance service reliably into the critical care transfer pathway. Firstly the air ambulance is tasked at present to be available to respond to severe road traffic crashes. There is a single aircraft and it cannot be relied upon to be available at all time both for reasons of other operational distractions or maintenance. In addition it is not clear from the evidence or experience of senior clinicians that an air ambulance transfer to Great Ormond Street would have been quicker than the 77 minutes that the road ambulance took to transfer the patient to Great Ormond Street. This option requires more detailed evaluation before we can be specific about the role of air transfer in future emergencies.

Therefore notwithstanding the specific difficulties of arranging a suitable ambulance transfer in BN's case, there remain problems related to critical neurosurgical transfer to London from the peripheral areas of Kent, Surrey and Sussex, related to the rarity of the event in the experience of local hospitals, the awareness of staff as to the correct protocols that should be operated when those rare circumstances do occur, the availability of retrieval services including air ambulance, and the readiness and training of senior local critical care staff to be able to effect such transfers.

We believe that the situation can be improved in the following ways.

Firstly in the next month we will issue interim guidance to acute hospitals which will contain the following:

1. All hospitals should maintain a suitably equipped paediatric and indeed adult transfer bag which contains all the equipment necessary to affect a road or indeed air ambulance transfer. This equipment should be subject to regular checking.

2. SECAMB will issue interim local guidance on the correct protocols to be followed in the event of these relatively uncommon events (in the experience of individual hospitals).

3. Training will be offered to critical care staff in all district general hospitals in retrieval. This is currently a requirement of doctors in training in critical care to receive. However it is not clear the degree to which these skills are available at all times within all of our local hospitals and a programme will be established to ensure that it is so. This programme will be established within the next month.

This guidance will make it less likely that operational problems will delay important transfers in the short term.

Secondly we are in the process of mobilising commissioning arrangements in particular the Paediatric Neuroscience Clinical Reference Group of NHS England and the South London and Kent Trauma Network (run from Kings College Hospital – adults only) for a more comprehensive discussion about standardising protocols between the local neurosurgical receiving units (Kings College Hospital for adults and Great Ormond Street for paediatrics). These arrangements will need to encompass at least two

ambulance services (South East Coast and London) and will build upon and standardise the interim guidance that we will issue in our locality.

Finally we will commission a report that looks specifically at the feasibility of building the air ambulance service more closely into the critical care neurosurgery pathway in these circumstances.

Therefore I believe we have taken immediate steps to improve the quality of care provided in these important but unusual circumstances. There are several longer term actions that I have outlined that will need time to come to a satisfactory conclusion and I will write to you in three months' time to summarise the outcome of these issues. I trust that this is satisfactory.

Yours sincerely

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[redacted]
Medical Director (Kent and Medway)

CC: [redacted]