North East Ambulance Service NHS
NHS Foundation Trust

Our ref: HMC/906
Your ref: AB/CEH/JT/15/11

23 June 2015

Strictly Private and Confidential
Ms Carly Elizabeth Henley
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By Email: -
[redacted]

Dear Madam,

Re: Ms Barbara Patterson (deceased)

I write with regards to the Regulation 28 Report dated 21 May 2015, which raised a number of concerns in connection with the inquest touching upon the death of Ms Barbara Patterson on 02 January 2015 at Wansbeck General Hospital.

Those concerns raised within the Regulation 28 Report are shown below;

1. The failure by the Call Handler to give timely advice in respect of CPR.

2. During the inquest evidence was given that the Pathways system, a computerised system piloted in the North East and since rolled out for use by 6 other Healthcare Trusts nationally, has a fault in that it does not advise non clinical call handlers to issue CPR advice unless a patient has stopped breathing. This fails to recognise the need for CPR in cases of Aganol (heavy/noisy breathing which is insufficient to sustain life). This fault was pointed out to Pathways by the Clinical Section Manager for North East Ambulance Service NHS Foundation Trust. Prior to the latest update being installed in early 20 14 (Update 9). Pathways refused to amend the system. That fault remains in place to date.

3. The failure by the ambulance dispatcher to dispatch an ambulance closer to the deceased's location.

4. The target time for the arrival of the ambulance was 8 minutes, this was breached. .The ambulance did not arrive for 15 minutes.

5. During the inquest evidence was given that there is a national shortage of paramedics, which is particularly acute in the North East.

6. During the inquest evidence was given that ambulance availability is being jeopardised by crews being delayed at hospital when handing patients over to Accident and Emergency staff.

I have attached the Trust's response to each issue, which you requested by 14 July 2015. As such, the Trust's response repeats the evidence which was given at the Inquest, based on your comments that you were satisfied with and grateful for the efforts which the Trust had taken with respect to its investigation and production of management evidence.

I understand that you were mindful at the Inquest that much of the information to be included in the Trust's response had already been shared by the Trust in its evidence disclosed prior to, and considered at, the Inquest.

Finally, I think it is worth highlighting that the national operational standard for ambulance trusts, as defined within the NHS contract, is for 75% of Red 1 (patients in respiratory or cardiac arrest) and Red 2 (all other life threatening emergencies) incidents to be responded to within 8 minutes.

This standard is measured Trust performance as an ambulance provider as opposed to performance with an individual Clinical Commissioning Group, i.e. Northumberland.

Yours faithfully,

Yvonne Ormston

Yvonne Ormston
Chief Executive