Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

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CHAIR AND CHIEF EXECUTIVE'S OFFICE

Your Ref:
Our Ref: TM190/JTF

4 January 2016

Mr A Barkley
The Coroner
Rock Grounds
Aberdare
CF44 7AE

Dear Sir

Re: Inquest touching on the death of Christopher George Connor

I am writing to provide the response of the Welsh Ambulance Services NHS Trust to the Regulation 28 Report on the Prevention of Future Deaths following on from the inquest touching on the death of Christopher George Connor received from you on 17 November 2015.

The concern which you identified during the course of the inquest specifically related to a delayed ambulance response to Mr Christopher George Connor on 16 August 2015.

I note that the PFD report states:

> *"The delay in the attendance of an ambulance which, on the evidence, only arrived after police officers arrived on scene and "expedited" the call to the ambulance control room".*

By way of background, in addition to your PFD report, I can confirm that the Trust received a concern from [redacted], the deceased's widow on 3 November 2015 regarding our delay in responding. On receipt of this concern an investigation was undertaken surrounding the circumstances of the delayed response pursuant to the NHS (Concerns, Complaints and Redress) (Wales) Regulations 2011 ('the Regulations'). As a consequence of this review the Trust reported the incident to Welsh Government on 6 November 2015 as a Serious Adverse Incident.

I am in a position to confirm that the investigation into this incident has been completed and Mrs Connor has been informed of the outcome. To offer you assurance that the Trust has learnt from this incident and acted upon these lessons, I will set out the chronology of the timelines of the incident, the findings of our investigation and the actions taken in response to the findings. I trust that this will provide you with the answer to the concern raised in your PFD report and will also demonstrate our openness regarding the root cause of this delay.

Chronology

At 01:28hrs on the 16 August 2015 the Trust received a 999 call for a male lying in the street in Treherbert. This call was prioritised as a Red 2 which recognises the call as potentially life threatening with a target response of 8 minutes in 65% of occasions.

At the time of this call the Clinical Contact Centre allocator inputted into the system that there were no vehicles available to respond.

A second 999 call was received at 01:35hrs for the same incident which was also prioritised as a Red 2.

A further computerised search for an available ambulance was undertaken and at 01:56hrs an ambulance was allocated to the incident from Aberdare.

One minute after allocation of this vehicle, a third call was received in relation to this incident from South Wales Police informing our Clinical Contact Centre that they had received a call for this patient. The Trust call taker who had remained in contact with the caller identified that a police officer arrived at the scene at approximately 02:00hrs.

The Ambulance arrived on scene at 02:23hrs, 55 minutes after the initial 999 call.

Investigation Outcome

In relation to your concern raised in your PFD report, our investigation does identify that an ambulance was allocated to this incident one minute prior contact by South Wales Police.

However, I am extremely disappointed to report that the investigation has identified two failings with our Clinical Contact Centre in the way that this incident was managed, these were:

1. At the time of the first two calls (01:28 and 01:35) the Trust had available two Rapid Response Vehicles which are solo paramedics in a car, one of these should have been allocated. Had one of these been allocated we would have had a paramedic at the incident within approximately 10 minutes. Whilst this paramedic would have been able to administer 'Advanced Life Support', he/she would not have been in a position to convey Mr Connor to Hospital.

2. Both 999 calls from the public were incorrectly categorised as Red 2 calls, audits of these calls have suggested that they should have been categorised as Red 1 calls. This categorisation has the same response standard as a Red 2, but identifies patient who have ineffective breathing or in cardiac arrest

Actions Taken

The investigation determined that the root cause of the failings emanated from one individual member of staff. Specifically the Clinical Contact Centre Allocator and I can confirm that the Trust has acted upon these findings in relation to that individual who is currently being managed in line with the Trust's relevant policies and procedures regarding the failings identified. I can assure you that the Trust views matters of this nature extremely seriously and in addition to the above, all the call takers involved in this incident have also received additional education and support.

As stated above, the Trust has received a concern from [redacted] we have provided an initial response to her concern which will continue to be managed in line with the Regulations.

I hope that you are satisfied from the content of this response that the Trust has taken this incident extremely seriously and investigated it accordingly. In the event that you have any further questions or require any additional information, please do not hesitate to contact me.

Yours sincerely

Tracy Myhill

Tracy Myhill
Chief Executive