North West Ambulance Service NHS

NHS Trust

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HM Senior Coroner John Pollard
Coroners Area of Manchester South
2 Mottram St
Stockport
SK1 3PA

10 June 2016

Dear HM Senior Coroner Pollard

Re: Inquest into the untimely death of Christopher Philip Fields
Date& Time of hearing: Monday 11th April to Thursday 14th April 2016
Location: Stockport Coroners Court
Matter: PFD Regulation 28 Report

Thank you for your letter dated 19 May 2016 which encloses a copy of the Regulation 28 report issued against NWAS, pursuant to paragraph 7, Schedule 5 of the Coroner's and Justice Act 2009 and Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013.

I note your specific concerns centre around the following:-

'2. The calls (999) to the ambulance service were properly coded and applied by the call taker leading to a Green 2 response. This should have led to the vehicle attending within 20 minutes. In the event, the vehicle did not arrive for 2 hours 8 minutes. Why was the response time so dramatically lengthier than prescribed and is this a matter of resources? (NWAS)

3. The fact that the call taker coded the call properly and yet this case involved a patient who was clearly critically injured and despite that fact it still did not generate a Red response, suggests that the algorithms used for coding are not accurate and not fit for the purpose. In my view this is an extremely serious flaw and may/will lead to future deaths occurring unless it is remedied. (NWAS, SECRETARY OF STATE and NHS ENGLAND).

Taking each point in turn, I confirm that the vehicle response time for the incident in question, was inextricably linked to the activity pressures, NWAS faced during this extremely challenging winter period. Despite winter weather contingency planning, activity within the Greater Manchester area saw an unexpected 22% increase, which was directly compounded by significant hospital turnaround pressures faced at Stepping Hill, North Manchester and Oldham.

The wider NHS reported similar pressures and it is recorded that Yorkshire Ambulance Service declared a Major incident at 14:30 due to the volume of work they faced on the date in question.

It should be noted that Green 2 response times are *'as soon as practicable'* and whilst NWAS strives to attend these types of incidents as soon as practicable, due to the challenges faced on the date in question, the response time was regrettably longer than we would have hoped.

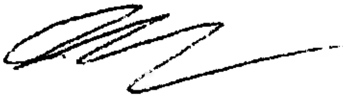
NWAS is currently exploring better ways to minimise lengthy waits during high demand periods and has also secured funding for 400 additional frontline staff and 60 new vehicles which I hope will assist in alleviating some of these pressures.

In regards to AMPDS system, I confirm that based on the priority symptoms given during the 999 call, the system correctly coded the incident as a Green 2. It should be noted that if the patient's chest had been *'concaved in'* this would have directly affected his respiratory system and been captured during the breathing algorithm question, resulting in a higher response. I note that the attending police officers evidence supported that the patient was breathing, conscious and able to walk, when they attended the scene, shortly after the first call which supports that the patient's condition, at that time was not time critical, requiring an 8 minute response (life sustaining treatment). Furthermore this assertion was reinforced by [redacted] Pathologist report which supported that the critical injury was sustained during the second assault.

I hope you will accept that these are very difficult issues to resolve, with no quick fix solutions, but continued efforts are being made to consider better ways of managing these challenging periods.

If you do have any further concerns or questions please feel free to contact me.

Kind regards



[redacted]

Head of Legal Services