NHS
East of England
Ambulance Service
NHS Trust

Headquarters
Melbourn Ambulance Station
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

16 April 2019

FAO: Jacqueline Lake
Senior Coroner for Norfolk

[redacted]

Dear Ms Lake

I am writing in relation to the inquest into the death of Robert Chandler, which took place on 20th February 2019, and the Regulation 28 Report to Prevent Future Deaths you sent to the Trust dated 21 February 2019. I understand that you called Chris Hewetson, the Trust's AOC Business Continuity and Patient Experience Manager to give evidence on behalf of the Trust and he was accompanied by Philip Sweeney, Area Clinical Lead.

Within your report you have identified four areas of concern:

- The Mangar Elk inflatable chair was intended to be used to lift Mr Chandler to the ambulance. One section did not inflate and so Mr Chandler was lifted underneath his arms and transferred to a chair borrowed from a local supermarket, no pain relief was given to Mr Chandler before being placed into the ambulance. He was later diagnosed with a pneumothorax. No safety straps were used.
- Staff are required to ask for assistance when required and are responsible for checking that equipment is present at the start of each shift. The evidence is that this is not always done as during periods of extreme demand, a crew may be allocated and sent to an incident before the check is completed.
- An electronic tablet was used initially to record the incident but this was not sufficiently charged to record all information. Paper records were not adequately completed.
- The incident occurred in September 2018 and the internal investigation report with recommendations was completed in January 2019. Recommendations within the report and in particular a clinical debrief had not taken place at the time of the inquest (February 2019).

Although I appreciate these did not contribute to Mr Chandler's death, I welcome the opportunity to address these issues and have done so below:

Mangar Elk malfunction

The Mangar Elk equipment is used by staff in order to assist patients who have fallen. All devices are serviced on an annual basis in line with the manufacturer guidelines. If a fault is detected then it is managed in line with our Medical Devices Policy and either reported on our incident reporting system or tagged as faulty. It is then assessed by our Clinical Engineering Department and fixed as required.

You will appreciate that equipment can malfunction at times and we do have a process in place in order to manage these issues. Unfortunately on this occasion the individual did not raise an incident at the time, although I can confirm the equipment was identified as faulty and fixed. I will ensure that further investigation takes place in relation to the clinician's statement that the equipment malfunction was reported as an incident.

In terms of your comments regarding pain relief and safety straps, Entonox is not indicated with potential chest injuries so IV cannulation would be needed to administer the drug. The crew felt to do this they would need to take many layers of clothes off the patient in a cold outside area and it was more appropriate to complete when in the ambulance. The Mangar Elk piece of equipment does not have safety straps attached to it as the safety element is managed by the attending ambulance staff.

Vehicle/equipment daily checks
The Trust has a process in place for vehicle/equipment daily checks to take place before the start of every shift. The vehicle daily checklist is completed by the crew and identifies any issues with the equipment on the vehicle. There are some exceptions to this if the crew are required to attend to the call immediately, however the general practice is to complete a vehicle daily check prior to the start of shift. It should also be noted that although a check list would identify that this particular piece of equipment is on the vehicle, it would not be practicable to test the function during this check due to the time taken to both inflate and deflate the device prior to responding to any incidents awaiting attendance

ePCR failure
The Trust encourages all staff to complete electronic Patient Care Records however there are times when this is not possible due to the nature of the incident or if there are technology issues. To ensure this does not impact on patient care, the ambulances are all stocked with paper Patient Care Records and a paper record was completed on this occasion. I can assure you this did not impact on the quality of care provided to the patient at that point in time. Unfortunately, the paper record was not completed to the standards the Trust details within the Patient Records Policy and this has already been addressed with the member of staff and formed part of the clinical debrief, which took place on 6th March 2019.

Timeliness of clinical debrief
The Trust endeavours to complete all actions arising from Serious Incidents as soon as possible and we currently have a team who are focussing on the quality of incident investigations and also monitoring actions from incidents. The Trust has recently appointed to a Patient Safety Integration Lead in order to better embed learning from both internal investigations or concerns and external best practice. This is in its infancy but will support timely closure of actions from SIs, investigations and patient experiences which we hope will provide assurance that lessons will be learned in a more timely way. The clinical debrief has now taken place and the Area Clinical Lead who supported this advises the crew were very moved by the family's written statement and learning has taken place around ensuring good communication with everyone.

I understand you also had concerns about delays, ambulance resources and recruitment however you were satisfied with the responses that Chris provided in relation to these issues. However if you have any further queries, please let me know.

The Trust's Acting Chief Operating Officer, [redacted] would be happy to meet with you to discuss any of the issues in this letter or any other matters. Please let me know if you would like me to arrange this.

Please do not hesitate to contact me should you require any further information.

Yours sincerely

Dorothy Hosein
Interim Chief Executive