HMC Ms Alison Mutch

Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

National Medical Director
& Interim Chief Executive, NHSI
Skipton House
80 London Road
London
SE1 6LH

23 September 2021

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – Jack Goodwin (15 January 2020)

Thank you for your Regulation 28 Report to prevent future deaths (hereafter "report") dated 11 February 2021 concerning the death of Jack Goodwin on 15 January 2020. Firstly, I would like to express my deep condolences to Jack's family. I am sorry that my response has been delayed.

Your report concludes Jack Goodwin's death was a result of:

1a) Chest infection on a background of hypoxic brain injury
1b) Cardiac arrest
1c) Ischaemic and hypertensive heart disease
II) Urinary Tract Infection

Following the inquest, you raised concerns in your report to NHS England and NHS Improvement (NHS E/I) about the call script not allowing for discussion about the call maker making their own way to the emergency department or providing a realistic timescale for the ambulance arriving.

All ambulance services are responsible for having in place scripts and procedures for dealing with delays in responding when under operational pressure. It is not possible in practice to offer an accurate arrival time for any given patient, but ambulance services will know an approximate current waiting time for that category of patient. NHS E/I support a position that callers should be provided with sufficient information to make informed decisions if an ambulance has not been despatched to the patient.

The Ambulance Transformation Forum, chaired by NHS E/I and including representatives from all ambulance services in England, discussed this in April 2021. Following piloting of the provision of an estimated time of arrival it was concluded that providing an accurate estimated time of arrival for an ambulance that had been dispatched to a patient is not practicable, largely due to the common and necessary

practice of diverting lower priority ambulance responses to higher priority incidents. This could lead to patients receiving multiple cancellations and renewed estimated times of arrival. There was strong support for providing more accurate likely waiting times particularly for lower acuity patients. Ambulance services have committed to amending their case exit scripts, where necessary, to provide an estimated waiting time for these lower acuity calls. During the Covid-19 pandemic ambulance services have also enhanced their case exit scripts where significant delays may have occurred to advise callers of the option, due to the long estimated waiting time, that they could make their own way to an emergency department or urgent treatment centre.

Furthermore, you raised the following concerns and I include my response to each in turn:

1) the call script having no provision to emphasise that the patient needed to be taken to an acute hospital with an emergency department

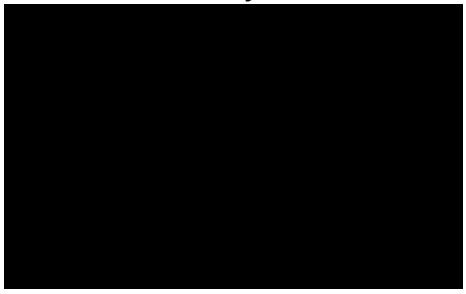
999 calls to the ambulance service can be answered anywhere in the country so we cannot rely on local knowledge; call handlers do not have immediate access to which is the nearest emergency department in those situations where a caller advises that the patient would make their own way to hospital. In appropriate circumstances, NHS E/I consider that advising the caller that they should make their way to the nearest emergency department, noting that not all hospitals have emergency departments, would be a useful addition to the script callers receive. This will be explored through the Ambulance Transformation Forum.

2) the call script did not emphasise in such a way the importance of the call maker making a further call if Mr Goodwin's condition further deteriorated so that there could be a further assessment of urgency

Instructions on worsening conditions, including specifically to call back on 999 should the patient's condition change or deteriorate, are standard components of the case exit script. If this was not provided in a clear and easy to interpret manner this is a matter for ambulance services to resolve locally as a training issue for call handlers.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director
NHS England and NHS Improvement