NHS
South East Coast Ambulance Service
NHS Foundation Trust

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[redacted]
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Ms S Hayes
HM Assistant Coroner for Mid Kent and Medway

[redacted]

23 September 2021

Dear Madam

Steve Cooke deceased

I write in response to the Regulation 28 Prevention of Future Deaths report issued on 8th August 2021 following the inquest into the sad death of Mr Cooke.

I was very sorry to learn of the death of Mr Cooke and I would like to convey my heartfelt condolences to his family and friends.

I have asked the Senior Management Team in charge of our 999 and 111 services to investigate your concerns. They have looked at two issues:

1. **Our process for establishing the address to which to send an ambulance**

   It has been identified that whilst there was in place clear instruction to 999 call handlers that the caller must give the address rather than the handler suggesting it, this instruction had not been replicated in the 111 system. This is being remedied.

   For 999 calls, the "EOC (Emergency Operations Centre) Call Handling Procedure states in paragraph 2.1:

   2.1.1. 999 call answer and incident entry should be followed as per NHSP training.

   2.1.2. Any address taken by an EMA that does not match to the EISEC return received from BT must be confirmed to ensure that it is correct. ***This must be confirmed by the caller giving the address and not the EMA reading it back to them****.*

This is now being replicated in the 111 service by way of an Operational Bulletin, a copy of which is attached. The Bulletin will be in force as soon as it has gone through internal governance, which should take one to two weeks.

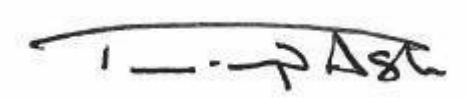
2. Our process upon a patient not being found by crew on scene

A further Operational Bulletin has been written to update and improve our process when crew on scene are not able to locate the patient. I attach a copy. It will be noted that the process involves the escalation of the incident to a team leader who will listen again to the original call to verify the address, search our records for any previous calls from the same telephone number and identify any sources of further information such as next of kin or a careline. If the team leader can locate a family member or careline to call, they must give a full explanation and allow the recipient of the call time to understand what is being said and provide a meaningful response. Checks will also be made of local hospitals and Police.

This bulletin is also making its way through internal governance and is expected to be in force within one to two weeks.

I trust that this provides assurance that the concerns identified in this inquest have been addressed and that if similar circumstances were to occur in the future, our chances of finding the patient are much improved. If I can be of further assistance or can provide any further information, please do not hesitate to contact me.

Yours sincerely



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Chief Executive Officer
South East Coast Ambulance Service NHS Foundation Trust

Attachments:

1. Operational Bulletin – *111 Ambulance dispatch calls and confirming address process*
2. Operational Bulletin – *Patient Location Verification Process*