Browne Jacobson

Reports to Prevent Future Deaths: What are the issues affecting ambulance trusts nationally?

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Whilst the main purpose of an inquest is to determine how a person came by their death, a coroner must also consider whether the evidence reveals ongoing concerning circumstances that create a risk of other deaths occurring in the future. Where such a risk exists, a coroner is under a duty to issue a report to Prevent Future Deaths, commonly known as a PFD report (or Regulation 28 report).

In a healthcare context, a PFD report can be an important tool to improve public health, welfare and safety. Healthcare organisations can learn and improve not only from PFD reports that are issued directly to them, but also from PFD reports concerning organisations of a similar nature. With that in mind, we have reviewed fifteen PFD reports that were issued in the six months between October 2022 and March 2023, all involving ambulance services. (The deaths themselves occurred between May 2021 and June 2022.) We have analysed the reports to discover themes and issues that are affecting ambulance services nationally. Our findings are set out below.

At a glance…

- Six of the PFD reports were addressed to the Secretary of State for Health and Social Care, one to the Minister for Health and Secondary Care and one to the Minister for Health and Social Services (in Wales), suggesting that many of the risks identified need to be resolved at a national, as opposed to local, level.
- As perhaps expected, the most common theme or risk arising was delayed ambulance response times.

Delayed ambulance response times

Sadly, delayed ambulance response times was highlighted as a risk in thirteen out of the fifteen PFD reports. Numerous issues were identified as causing ambulance delays, including staff shortages, lack of resources (due to a high demand for ambulances) and handover delays at acute hospital sites, meaning that patients cannot be admitted to a hospital bed and ambulances are delayed in returning to their normal duties. (It should be noted that acute hospitals are often unable to discharge people who are medically fit from hospital, due to a shortage in appropriate social care beds or community care packages.)

In eight cases involving ambulance delays, PFD reports were issued to English and Welsh government ministers. We could not locate a response to six of the PFD reports that were issued to English government ministers. Only one PFD report had been responded to by Will Quince MP, Minister for Health and Secondary Care. This response stated that long ambulance waiting times and issues with handing over patients to hospitals have been focussed on in the government's "Delivery plan for recovering urgent and emergency care services", published in January 2023. The plan aims to "*bring down A&E and ambulance wait times significantly over the next year*" and includes the delivery of 800 new ambulances. The response also promises additional funding to enable the NHS to buy up beds in the community so patients can be safely discharged from hospital, to reduce ambulance handover delays.

From a Welsh perspective, The Minister for Health and Social Services in Wales admitted that at times, demand for ambulances has outstripped capacity and that this has resulted in long delays, and poorer experiences and outcomes for some patients. The Minister highlighted that "*significant investment in urgent and emergency care [has been made] this year [2023], with a dedicated budget of £25m annual funding to support local, regional and national delivery of the Six Goals for Urgent and Emergency Care, our five-year strategy published in February 2022, to drive a whole-system transformation of access to urgent and emergency care*." She explained that the

programme has "*a specific focus on patient flow through the hospital system and out into the community, as well as significant investment in urgent primary care and same day emergency care to help reduce pressure on 999 services and emergency departments*." She also referred to a range of improvements being introduced by investment, including new triaging and video consultation technology, staff recruitment across the Welsh Ambulances Services Trust in order to fill vacancies, implementation of new staff rosters for emergency medical services and the delivery of workforce efficiencies.

Algorithms and categorisation for dispatch

Two of the PFD reports bore striking resemblances. They both concerned gentlemen who were taking blood thinning medication. Both had fallen at home and suffered a head injury, which had bled persistently. This resulted in a category 3 ambulance response, with a target time of 2 hours. Each ambulance was delayed, one taking nearly 8 hours to arrive. Both men died shortly after their arrival at hospital, as a result of their head injury.

The PFD report for each death highlighted that the International Academies of Emergency Dispatch system algorithm (a protocol system used for emergency call taking) does not consider whether a patient is on blood thinning medication when deciding the category of emergency response required for a head injury that is bleeding persistently. One report highlighted the coroner's concern that, if the algorithm isn't changed to take into account the effect of anti-coagulant medication on a head injury, deaths will occur in the future.

Clinical guidelines

Another recuring theme was in relation to clinical guidelines. In one PFD report, it was highlighted that, whilst waiting in an ambulance for a hospital bed to become available, a person's physiological observations were not undertaken regularly in accordance with the ambulance service's guidelines. In another PFD report, it was highlighted that if a patient is considered to be in the "Amber 1" category, a further assessment *might* be undertaken to decide whether the ambulance response should be expedited. However, this seemed to be an ad hoc arrangement, that was not underpinned by local policy or guidelines, and the coroner therefore sought reassurance of the process for re-assessment of a patient's clinical condition whilst awaiting an ambulance. Lastly, one coroner raised concerns about the adequacy of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines in relation to the delivery of breech babies. These guidelines suggest that breech presentation babies can be delivered at home. Whilst this is possible for bottom first presentations, the evidence at the inquest was that delivery of footling breeches should *not* be attempted at home. The coroner therefore addressed her PFD report to the JRCALC.

Browne Jacobson has extensive experience of advising ambulance trusts on inquest processes and procedures, including PFD reports. If you would like further advice or guidance, please do get in touch.

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