Dozens of deaths after failings by ambulances and 999 call handlers

Kat Lay Health Correspondent

Almost two patients die a month on average after failings by the ambulance service, including delays or a failure to recognise the severity of symptoms, a review of coroners' reports has found.

Coroners in England and Wales have written to ambulance services or call handlers 86 times since July 2013 warning them that they need to make changes to prevent future deaths.

Forty-eight of the warnings related to ambulance delays or problems with call handling, according to the review by Minh Alexander, a former whistleblower who now campaigns on patient safety. She said the volume of reports suggested a "significant decline in ambulance safety in recent years".

She added: "Action is needed to rectify underfunding, related workforce and skill mix issues, and pressures on the whole NHS that spill on to ambulance services."

Coroners have a duty to write a report under regulation 28 of the Coroners (Investigations) Regulations 2013 if it appears there is a risk of other deaths occurring in similar circumstances. Dr Alexander, a psychiatrist who raised concerns about patient deaths, produced her report by analysing section 28 reports published by the chief coroner.

A number of the reports highlight delays caused by slow handovers at A&E departments, echoing warnings from the National Audit Office earlier this year. In many cases the delay was not found to have caused the deaths but coroners were sufficiently concerned by what they heard at inquest to warn ambulance service bosses that delays could be fatal in the future.

In April, Gilva Tisshaw, assistant coroner for Brighton and Hove, wrote to South East Coast ambulance service following the death of Ronald William Bennett, warning of "serious delays in ambulances arriving at the scene of an incident as a consequence of ambulance crews being delayed at the accident and emergency department".

There were also a number of cases involving call handlers without medical training and their computer programmes failing to recognise the severity of a situation.

In June, Elizabeth Earland, senior coroner for the Exeter and Great Devon district, wrote to South Western ambulance service after the death of Colin James Sluman, 68, who had a burst varicose vein. He called an ambulance at 1.36am, but bled to death before an ambulance arrived at 3.03am.

Dr Earland said the protocol followed by call handlers, on which they were "completely reliant", did not recognise reports of dizziness in a patient on their own "as important triggers for a rapid response".

An ambulance service spokeswoman said the trust had taken action to address the concerns.

Martin Flaherty, managing director of the Association of Ambulance Chief Executives, said ambulance services took coroners' reports "extremely seriously" and would make changes in response where possible.

In 2016 English ambulances handled 10.7 million emergency calls.

Case study

Grant Benson, 21, died in a fire following a car accident in August 2014 after making a 999 call (Kat Lay writes).

Andrew Tweddle, senior coroner for County Durham and Darlington, wrote to the Yorkshire ambulance service (YAS) after the event. He said: "It is clear from listening to the recording how frantic the driver became as the fire began and took hold."

The car came off the road near Barnard Castle, County Durham, but the call handler at the YAS was based in Wakefield. She and two colleagues failed to pinpoint the crash location so an ambulance could be dispatched. The inquest heard that it was not possible to transfer responsibility for calls between emergency services, and one ambulance service could not send a vehicle from another. Emergency services attended only after a further call had been made by a passer-by.

A YAS spokeswoman said it had "taken steps to review local practice."

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