NHS
England
London Region
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2 June 2014

PRIVATE AND CONFIDENTIAL
Dr Fiona Wilcox,
HM Senior Coroner
Inner North West London
Westminster Coroner's Court
65 Horseferry Road
London, SW1P 2ED

Dear Dr Wilcox,

Thank you for raising the issues arising from the investigation and inquest into the death of Ms Falvo. I am responding on behalf of [redacted], Medical Director for London and [redacted] You raised two matters of concern:-

(1) The A&E departments have insufficient cover to ensure that they have on site clinicians able to secure airways via emergency tracheotomy.

(2) That the training planned and provided to those expected to manage and secure airways including the use as appropriate of surgical tracheotomy, is reviewed and upgraded such that those clinicians have both the skills and confidence to perform such procedures in an emergency situation.

First let me express regret at this sad death and I share your wish that lessens can be learnt to reduce the risks of such a tragedy recurring.

There are insufficient experienced ENT surgeons to provide immediately available resident cover in all A&E departments at all times, and to do so would be impractical. Acute Trusts responsible for the provision of A&E services are expected to recognise and manage this risk by ensuring that general training is available to the initial receiving staff in A&E, and that specialist expertise can be accessed in a timely way. A&E senior staff are trained as part of Advanced Trauma Life Support (ATLS) in both tracheotomies and needle crichothyroidotomy. This is repeated at least every four years to ensure skills and confidence are maintained.

Across London there has been a review of Emergency Departments and the availability of senior staff with these skills as part of a wider review of Quality Standards in Acute Trusts. It is clear that provision has varied, and a standard has been agreed so that Major Trauma units have consultants on site 24/7 and all A&Es will have increased consultant presence over 16 hours with senior training doctors (ST4s) on site and available for the other time. This is a substantial challenge as there is a shortage of A&E doctors, but already many Trusts have made strides to meet these standards and this has also been a drive behind the reconfiguration of some A&Es.

The Urgent and Emergency Care review, currently being led by [redacted] is expected to lead to the development and designation of Emergency Centres and Major Emergency Centres, and ensuring that clear standards and robust plans are in place to deal with this and similar emergencies will be an important component of this development. The first stage report was published in November 2013 and further information is expected over the summer.

Whilst the circumstances are very unusual, we know that an emergency surgical airway will be required from time to time (perhaps once every 3-5 years in a typical A&E Department). Training in this procedure is already given to all those who provide advanced airway interventions in an emergency. This includes doctors specialising in A&E, anaesthesia and intensive care. Relevant guidelines are disseminated by the Difficult Airway Society and are widely taught and followed, with practical training using manikins and animal models (for example sheep larynx), during "Advanced Life Support" courses.

Because this is a very rarely performed procedure it is approached with trepidation by some. However, figures from the 4th National Airway Audit Project of the Royal College of Anaesthetists and Difficult Airway Society, completed in 2011, [redacted] on behalf of the Fourth National Audit Project. Royal College of Anaesthetists, London, March 2011] indicate that the success rate is generally very good when a surgical approach is used, as in this case.

It is clear that Ms Falvo presented more substantial challenges than other patients, with scarring and obstruction that made intervention much more complex than in is expected in these already very uncommon occurrences. Nonetheless the review and implementation of increased senior doctor in A&Es and the National Review of Urgent and Emergency Care will substantially reduce the risks of this tragedy recurring.

Yours sincerely,

[redacted]

Deputy Regional Medical Director
NHS England (London)

cc. [redacted] National Clinical Director for acute episodes of care
[redacted] National Medical Director