London Ambulance Service NHS
NHS Trust

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2 December 2016

Response to Regulation 28 Report relating to Patricia Mercieca deceased

I apologise for the delay in writing after receiving a copy of your letter dated 30 August 2016 from to HM Senior Coroner on 27 September 2016, arising from the Regulation 28 Report issued by Dr Wilcox after the inquest into the death of Patricia Mercieca.

Whilst supporting whole heartedly your wish to ensure that appropriate lessons are learned which may prevent future deaths I should like to respond to your invitation to the Coroner to consider:

"What steps could be taken by an emergency service when triaging calls where it is informed that a third party requesting an emergency response is not in attendance with the casualty. Tunstall feel that the London Ambulance Service 'script' failed to fully recognise this situation in the present case resulted in additional confusion between the respective call operators."

My understanding of the London Ambulance Service NHS Trust's call records concerning the call made on behalf of Ms Mercieca was that : a single call was made, it was known and recorded that it was a third party caller who was not with the patient. Regrettably when contact with Ms Mercieca was lost and Tunstall were unable to make contact again they did not update the LAS of that situation. Had Tunstall informed the LAS that communication had been lost and Ms Mercieca was

not responding, I am advised by [redacted], Head of Quality Assurance Control Services, who gave evidence at Ms Mercieca's inquest, that the call would have been upgraded to a Category A or Red call with a target response of 8 minutes for 75% Red calls . As [redacted] explained in her evidence while the call was being held awaiting an available response it was reviewed by an LAS clinician with the intention of making a clinical assessment by telephone, but without a contact telephone number the clinician upgraded the priority of the call from C2 to C1.

I am satisfied that there are no changes to the questions asked of 999 callers that would have enabled the LAS to triage the call differently aside from the update that contact with the patient had been lost and she was not responding. I am hopeful however, that the measures taken by Tunstall to address the Coroner's concerns will help prevent future deaths.

If you would find it helpful to meet and discuss further with [redacted] and our Deputy Director of Operations, Control Services please let my [redacted] know so that the arrangements can be made.

Yours sincerely

[redacted]

[redacted]

cc: Dr Fiona Wilcox , HM Senior Coroner, Westminster Coroner's Court