NHS
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NHS Trust

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Ms Mary Hassell
HM Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

23 August 2019

Dear Ms Hassell,

Regulation 28: Prevention of Future Deaths Report – Fern-Marie Choya

Thank you for your Regulation 28 Prevention of Future Deaths (PFD) report dated 31 July 2019. I would like to take the opportunity at the outset of my letter to offer my sincere condolences to Ms Choya's husband and family.

Thank you also for informing the London Ambulance Service NHS Trust (LAS) of the concerns you identified at the inquest into Ms Choya's death.

Having reviewed our original evidence in this case, following receipt of your PFD report, it has unfortunately become clear that the LAS provided inconsistent evidence in relation to its involvement in Ms Choya's death. The clinical opinion prepared by the LAS to contribute to the Healthcare Safety Investigation Board's (HSIB's) report and provided to yourself concludes "*It is notable that at 09:08, EAC A, contacted the sector desk in the control room, to request for further help, and to place a pre alert information call to the emergency department. During this call he alerted the dispatch desk to the information that informed the pre alert, and also mentioned the patient was pregnant.*" However, on reviewing the recording of the call in conjunction with the transcript, it has become clear that this was not an accurate representation of the communication between the crew and the Emergency Operations Centre (EOC). The salient point of the discussion between crew (G305) and the EOC is as follows:

"G305 - Current GCS is 3, over, and our ETA will be erm, 8 minutes, over.
EOC - Lovely, erm, so this is erm, pregnant, with a, did you say query PE, over.
G305 - A query seizure or something
EOC - All noted, passing for you now

Transmission Ends"

Whilst this transcript was previously provided to you prior to the inquest, a further copy is enclosed, for ease of reference. It is now evident from the tape and the transcript that the crew did not confirm to the EOC that Ms Choya was pregnant and that the EOC did not pursue and confirm this possibility either; this is why that information was not passed on in the pre-alert information call to the emergency department as suggested in the clinical opinion.

The LAS will be informing the HSIB about the inaccurate information that was fed into its report and will be providing the HSIB with details of the actions that the LAS has taken to avoid a recurrence of this. At the same time, an appropriate review of the LAS clinical opinion provider will be undertaken to highlight the importance of checking call details with the EOC, and in order to ensure accuracy and consistency in the Trust's approach in feeding into other organisations' reports.

The case had previously been considered by the Trust's Serious Incident Group as a potential serious incident. At that time it was not declared as such because the information relating to the call was not available; the decision was taken to work with HSIB and continue the investigation in order to bring the results of this back to the Group following the Inquest. These has now been received by the Group which has retrospectively declared this a serious incident. ..

The matters of concern you identified are as follows:

1. *The London Ambulance Service (LAS) emergency operations centre (EOC) made a pre hospital alert telephone call to the Whittington Hospital emergency department, regarding the expected arrival eight minutes later of a patient in respiratory arrest. This was good practice.*

   However, they failed to include in that alert the information that Ms Choya was pregnant. This was a crucial detail, which had been passed to the LAS at the very outset by her husband, and then again to the EOC by the emergency medical crew on scene.

Notwithstanding the fact that our further review of the transcript has indicated that it was both the crew and the EOC, rather than the EOC alone which failed to pass on the information that Ms Choya was pregnant, the LAS acknowledges that, had the correct information been passed, the focus of Ms Choya's treatment may have been different.

Prior to the Inquest, a meeting was held with the crew regarding this incident and feedback provided during this de-brief meeting. In addition, the crew are also to attend an observation session in the EOC for learning purposes (to be completed by 14 October 2019). Furthermore, the relevant Clinical Team Leader will be reviewing, with the crew, what they have learnt from that session and seeking confirmation that they will be following a structured approach every time they share information with the EOC about patients or hand them over to an emergency department in the future.

To support crews and the EOC, the LAS has also recently re-issued guidance (on 12 August 2019) to clarify the relevant details expected during pre-alert calls, to ensure that the appropriate clinical team is present on a patient's arrival. This guidance stipulates the CASMEET mnemonic (please see attached Bulletin). As a result of our learning from Ms Choya's death, the LAS has extended this guidance to include a request from the EOC for 'any other specific and critical information' at the end of the radio transmission when they repeat the information provided back to the crew. Operational staff will be made aware of this change.

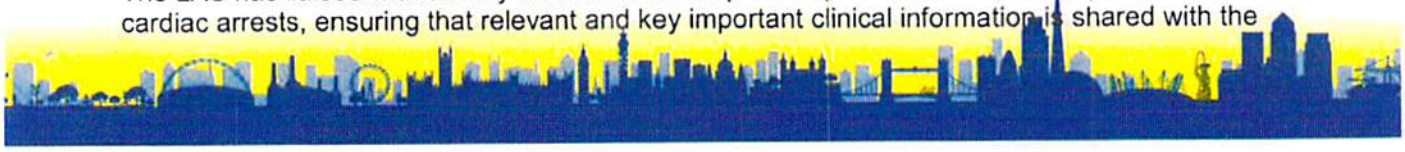
2. *On arrival at the Whittington Hospital, the detail of the pregnancy was not communicated effectively.*

   It is unclear whether the LAS crew did not mention the fact or whether the emergency staff simply did not hear it.

   In any event, it took 16 minutes post arrival for the pregnancy to be recognised and the obstetric team to be called.

The LAS currently utilises the SBAR tool for all patient handovers (Situation, Background, Assessment, and Recommendation). This enables crews to be confident that they have passed relevant information onto emergency departments when handing over patients, even in the most stressful scenarios. However, the importance of relaying the important medical information at handover has been stressed to the crew who provided care to Ms Choya, as part of the feedback and de-brief meetings referred to above.

The LAS has liaised with tertiary centres to develop a comprehensive handover procedure in relation to cardiac arrests, ensuring that relevant and key important clinical information is shared with the



receiving team. As part of this handover procedure, receiving teams are expected to observe a 30 second "hands off eyes on time" period to ensure quiet whilst vital information is conveyed using the ATMIST AMBO (age, time, mechanism/medical complaint, injuries/information related to complaint, signs, treatment – allergies, medication, background/history, other information) mnemonics. The LAS will be rolling out the extension of this handover tool/procedure to all receiving centres, as per the attached handover documents. Work will also be done to ascertain the feasibility of establishing a handover audit mechanism in the specification of the Electronic Patient Care Record (EPCR) that is being developed by the LAS alongside the introduction of its replacement Computer Aided Dispatch (CAD) system.

We have also already recognised a gap in understanding of maternity calls, between the EOC, frontline operations and maternity units. As such, the LAS has undertaken extensive learning around handovers and this will continue as part of the joint learning with the Whittington Hospital. The LAS uses 'Managing Maternity Emergencies in Pre-Hospital Setting' which was established in 2015. The LAS Practice Leads for pre-hospital maternity care updated this joint training in April 2019 to include staff working within the EOC. This was initially in response to identified areas for improvement regarding the communication and management of maternity calls from midwives working in the pre-hospital setting. Every multi-professional maternity training now involves operational road staff, EOC staff and midwives as well as maternity support workers.

Since April 2019, the LAS facilitated three joint training sessions which included EOC staff. These took place as follows:

- 30 April 2019 - Chelsea and Westminster Hospital and Fulham Ambulance Station.
- 16 May 2019 - Guys and St Thomas's Maternity Unit and Westminster Ambulance Station.
- 24 July 2019 - Guys and St Thomas' Maternity Unit and Westminster Ambulance Station.

We have discussed Ms Choya's case with the Whittington Hospital at Clinical Lead, Medical Lead and Director level and are in the process of arranging a session with the Whittington Hospital in light of the learning from Ms Choya's death.

3. *Without the obstetric team, the emergency department team focus was on the potential for a pulmonary embolism, and alteplase was given. Only later was a scan conducted and free fluid noted. By the time of the laparotomy it was too late to save Ms Choya.*

This is an issue for the emergency department at the Whittington Hospital; however, the LAS anticipates that a number of the measures that have been set out above will assist in ensuring that patients such as Ms Choya receive more timely care in the future. We will as mentioned above, seek to hold a joint training session with the Whittington Hospital in order to ensure that any further learning is shared between the two organisations.

An action plan has been devised in order to progress and complete the issues that have been identified in this case, this can be found attached.

Yours sincerely,

Garrett Emmerson
Chief Executive Officer