East Midlands Ambulance Service NHS
NHS Trust

Emergency Care | Urgent Care | We Care

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Our ref: [redacted]

22 March 2017

Mrs Heidi Connor
HM Assistant Coroner Nottinghamshire
Office and Main Court
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mrs Connor

Re: Report to Prevent Future Deaths: Dipa Rameshchandra LAD

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 31 January 2017, bringing to my attention the Coroners concerns arising from the inquest into the death of Dipa Rameshchandra Lad.

I would like to assure you that within the East Midlands Ambulance Service (EMAS) all matters related to patient safety are taken extremely seriously. Assurance around the availability of an ambulance in a timely manner to those requiring emergency aid is at the heart of the Trust's clinical delivery plan. This work is continuous however, I trust you will take assurance from the measures outlined in this response which are pertinent for the timeframe from the date of Dipa Rameshchandra Lad unfortunate death to the present day.

This process has been applied to the Prevention of Future Death notice pertaining to the inquest into the death of Dipa Rameshchandra Lad: The matters of concerns you have raised are:

1. *Is the EMAS deviation from national guidance safe as it currently stands? I do not know if this is a protocol adopted by other ambulance services around the country. I have copied the AACE into this report largely with this issue in mind.*
2. *The distinction between national guidance and local protocol is that EMAS crews may deem a resuscitation effort to be 'futile'. This is a clear and important deviation from national guidance, yet staff have been given no guidance about what a 'futile' resuscitation is. Whilst this may be clear in some situations, the protocol, if adopted, should give guidance where a situation is less clear – and perhaps consider providing that where there is any doubt, that full*

ALS protocol should be applied. As it currently stands, the protocol places a large burden on staff to ascertain 'futility' with no guidance whatsoever.

3. *It was clear that most of the staff attending this emergency were not aware of the change in local policy. On arrival of the team leader (who told us she was aware of the protocol), resuscitation efforts were stopped. I am concerned about the clear disparities in awareness of this important change to protocol.*
4. *We heard that EMAS relies on emailing changes in protocol to staff. There is no check that busy staff have read and understood these, and there has been no training on this change.*
5. *We heard that staff carry JRCALC pocketbooks as reference guides. EMAS policy around diagnosis of death differs in a key respect from JRCALC guidelines – but there is no equivalent pocketbook/amending to existing pocketbook/similar which reflects local policies.*
6. *I do not consider the current EMAS 'Diagnosis of Death Procedure' to be sufficiently clear/consistent (particularly when comparing the wording and the flow-charts). This also contains no guidance on when resuscitation should be considered 'futile', as referred to above.*
7. *One of the technicians who attended gave chest compressions standing up – with both feet on the same side if the patient. The reason she gave for this was not wanting to get blood from the scene on her trousers. She was not in a confined space, and when challenged by her team leader subsequently, used a towel to protect her clothes and continued to give compressions kneeling down. I am concerned to ensure that staff are trained/reminded of the best technique to give effective compressions – for the patient and for staff resilience reasons.*

I would like to reassure that we take these matters extremely seriously. Taking each of the concerns in turn, I set out below the actions EMAS have taken and our response to HM Coroner's concerns as detailed in the PFD notice.

Point One

1. *Is the EMAS deviation from national guidance safe as it currently stands? I do not know if this is a protocol adopted by other ambulance services around the country. I have copied the AACE into this report largely with this issue in mind.*

The development of the EMAS Diagnosis of Death Procedure has been reviewed and the procedure was developed around and is based upon current national guidance. Decisions Relating to Cardiopulmonary Resuscitation was a guidance document issued from the British Medical Association (BMA), the Resuscitation Council (UK) (RCUK) and the Royal College of Nursing (RCN) and was used when developing the procedure. The 3rd edition (1st revision) was published in 2016 and a copy has been included with our response letter. During the development of the procedure it was sent out for consultation to a wide range of stakeholders including HM Coroners across the East Midlands region and any feedback received was incorporated into the document. Following the amendments, the procedure was approved through the normal EMAS governance procedures.

Although the procedure was based upon national guidance and was deemed to be safe following this inquest the current EMAS Diagnosis of Death Procedure has been reviewed again against the national guidance. The revised version has been approved within EMAS and I have attached a copy for your reference.

Point Two

2. *The distinction between national guidance and local protocol is that EMAS crews may deem a resuscitation effort to be 'futile'. This is a clear and important deviation from national guidance, yet staff have been given no guidance about what a 'futile' resuscitation is. Whilst this may be clear in some situations, the protocol, if adopted, should give guidance where a situation is less clear – and perhaps consider providing that where there is any doubt, that full ALS protocol should be applied. As it currently stands, the protocol places a large burden on staff to ascertain 'futility' with no guidance whatsoever.*

As part of the review of the procedure and to provide guidance to clinicians who need to determine if their resuscitation effort will be 'futile' the appropriate section from the Decisions Relating to Cardiopulmonary Resuscitation guidance document from the BMA, RCUK and RCN has been incorporated in to the revised procedure. The guidance from the document provides the following information around 'futility' and when decisions not to attempt CPR because it will not be successful may be made. The following section has been added to the procedure to provide additional guidance to clinicians

> Whilst no specific definition of futility exists, a joint statement by the British Medical Association (BMA) Resuscitation Council UK (RCUK) and Royal College of Nursing (RCN) in 2016, entitled 'Decisions relation to cardiopulmonary resuscitation,' states the following:
>
> *i.e. 'if the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period. If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted.'*
>
> This joint statement is also supplemented by the Adult Cardiac Arrest best practice statement which was produced by the National Ambulance Services Medical Directors (NASMeD), a sub group of the Association of Ambulance Service Chief Executives (AACE), which documents
>
> *'Starting resuscitation inappropriately should be avoided if possible, and work should be undertaken locally to minimise this risk.'*
>
> *'If ambulance clinicians are as certain as they can be that a person is dying as an inevitable result of underlying disease, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted or it should be abandoned if already started by the general public or CFRs.'*
>
> Examples of these situations can include the following:

- Patients presenting in an asystolic rhythm following an aetiology of asphyxiation, i.e. adult strangulation, carbon monoxide poisoning, airway occlusion.
- Patient presenting as having suffered from serious single or multiple medical conditions with a poor prognosis and no DNACPR order in place.
- Apparent exsanguination.

The nature of these incidents will illustrate this list in not exhaustive and attending clinicians should use the above examples to determine comparative incidents.

Whilst the updated procedure does offer the guidance on futility it also adds. However, there will be circumstances that even despite the perceived futility of the resuscitation attempts, the attending clinician feels it appropriate to commence. This is equally understandable and endorsed by this procedure.

Point Three and Four

3. *It was clear that most of the staff attending this emergency were not aware of the change in local policy. On arrival of the team leader (who told us she was aware of the protocol), resuscitation efforts were stopped. I am concerned about the clear disparities in awareness of this important change to protocol.*
4. *We heard that EMAS relies on emailing changes in protocol to staff. There is no check that busy staff have read and understood these, and there has been no training on this change.*

To ensure that key information around changes to clinical practice are disseminated to clinical staff in July 2016 EMAS introduced a revised version of the Procedure for the Dissemination of Clinical Information to Clinical Staff Members.

As part of this review two classes of clinical bulletin were introduced. They are:

Red Clinical Bulletin = Extremely important/immediate patient safety implications if not noted by all clinical staff. "Read now". This bulletin should be infrequent but carries the utmost importance and confirmation of receipt and understanding of these bulletins is mandatory. This may be recorded electronically or by a physical signature.

Green Clinical Bulletin = Routine but essential clinical update information. All clinical staff need some awareness. "Read ASAP" This does not require formal confirmation of receipt and understanding. This will be published on a standard day to encourage awareness of publication dates - "change Wednesday".

A Red Clinical Bulletin should only be produced to address an issue assessed to be of significant risk to EMAS, its staff or patients. As such, receipt and understanding MUST be acknowledged by all staff to which it applies. All red bulletins must have specified staff group to ensure only relevant parties are required to confirm receipt and understanding.

Monitoring of sign off will be monitored on a weekly basis with the expectation that all available staff (i.e. not long term sick) will have confirmed understanding within 30 days. This is to allow for differing rostering patterns and staff attendance at work.

Any clinical bulletin issued should be considered for links and further promotional material within wider communications methods to include but not limited to:

- Weekly e-news (or any future method of staff communication tool)
- Payslip bulletin (requires Executive sign off)
- Electronic communications (Communications Direct or any future tool)
- Appraisals and ad hoc leadership activities

For extremely important information concerning clinical information personal mailing may be utilised. These will be used for extremely important communications relating to clinical information, where more detailed critical information is required than is able to be fitted within a Red Clinical Bulletin. These should not be simple letters but well prepared education packs containing all the relevant information in a clearly understandable format with appropriate algorithms, pictures of equipment, checklists etc.

To support the dissemination of information all clinical staff are required to undertake a classroom based statutory and mandatory training day each year. These sessions include updates and an assessment on resuscitation.

Point Five

5. *We heard that staff carry JRCALC pocketbooks as reference guides. EMAS policy around diagnosis of death differs in a key respect from JRCALC guidelines – but there is no equivalent pocketbook/amending to existing pocketbook/similar which reflects local policies*

To support clinicians and assist clinicians with recognising when resuscitation may be futile, an action card has been updated to include the relevant parts of the update of the Diagnosis of Death Procedure which assists with identifying the key features if managing a cardiac arrest with appropriate management plans. This will include the guidance around 'futility' and when resuscitation should not be commenced/continued. The action cards will be issued to all ambulance clinicians to support them within their role.

Point Six

6. *I do not consider the current EMAS 'Diagnosis of Death Procedure' to be sufficiently clear/consistent (particularly when comparing the wording and the flow-charts). This also contains no guidance on when resuscitation should be considered 'futile', as referred to above.*

The existing EMAS Diagnosis of Death Procedure was developed at the end of 2015/beginning of 2016 and as part of the review process, the document was sent to all of HM Coroner's that cover the East Midlands region. Any feedback we received, including that from HM Coroner for Nottinghamshire, was incorporated in the Procedure. Following your concerns, we have revisited the procedure and clarified the areas of concern to improve clarity and consistency between the wording in the text of the document and the flowcharts. Additional guidance around futility has been included in line with the Decisions Relating to Cardiopulmonary Resuscitation guidance document from the BMA, RCUK and RCN.

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Point Seven

7. *One of the technicians who attended gave chest compressions standing up – with both feet on the same side if the patient. The reason she gave for this was not wanting to get blood from the scene on her trousers. She was not in a confined space, and when challenged by her team leader subsequently, used a towel to protect her clothes and continued to give compressions kneeling down. I am concerned to ensure that staff are trained/reminded of the best technique to give effective compressions – for the patient and for staff resilience reasons.*

Although the most appropriate technique to perform CPR is to be kneeling close to the patient or standing over the patient this cannot always be possible and staff will conduct their own dynamic risk assessment when performing chest compressions. All clinical staff are trained in delivering effective chest compressions and undergo an annual statutory and mandatory refresher training course which includes updates and an assessment on resuscitation in one of our education centres.

The content of this letter is intended to demonstrate that EMAS has taken significant steps in reviewing the procedure and providing appropriate support and guidance for clinicians when dealing with cardiac arrest patients. I can assure you that lessons have been learnt from this incident and we are taking the necessary actions identified with a view to ensuring that similar events are avoided wherever possible in the future.

Please do not hesitate to contact me should you require any additional information, or any clarification, in connection with the above.

Yours sincerely

[redacted]
Acting Chief Executive

Encs.

[redacted]