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East Midlands
Ambulance Service
NHS Trust

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CONFIDENTIAL

Our Ref RH/PFD

26 March 2018

Mrs A Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tobor Street
Stockport
SK1 3AG

Dear Mrs Mutch

Re: Report to Prevent Future Deaths: Master George Edward FRENCH-RUSSELL (deceased)

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 1st March 2018 (received on 2nd March 2018), bringing to my attention HM Coroner's concerns arising from the Inquest into the death of Master George Edward FRENCH-RUSSELL.

I would like to assure you that within the East Midlands Ambulance Service (EMAS) all matters related to patient safety are taken extremely seriously. In particular, matters arising from Coroners' Inquests from which lessons can be learnt, including Prevention of Future Death Reports, are discussed within the Incident Review Group and Lessons Learned Group.

This process has been applied to the Prevention of Future Deaths notice pertaining to the Inquest into the death of Master George Edward FRENCH-RUSSELL.

The **MATTERS OF CONCERN** specific to EMAS are as follows:

1. **During the inquest it became clear that during the telephone conversation between EMAS and George's mother her labour was rapidly developing. There was no evidence of the call taker seeking guidance on how to deal with a rapidly evolving situation other than to update the ambulance crew who were on en route (EMAS)**

2. **The way in which information was exchanged between Stepping Hill Hospital and EMAS meant that all those involved in making decisions were not in possession of key facts. There was no structure to how information was shared and it was passed 3rd hand**

3. **During labour EMAS were present. The paramedics did not have the experience to deal with a footling breech. Expert input given for a brief period by a registrar but when the that conversation was terminated there was no further support given or sought**

I set out below the actions that EMAS proposes to take and our response to HM Coroner's concerns as detailed in the PFD notice.

Point One:
The EMAS emergency operations centre (EOC) has in place a structured triage and escalation system to ensure that patient safety is embedded across the call handling and dispatch systems. Our advanced priority medical dispatch system (AMPDS) is designed to enable an objective clinical prioritisation of all callers; within this system is the ability to amend clinical details in the event of a change in condition. This is included within the system design, training programmes and audit processes. The result of any new information could create an amended prioritisation (escalation of priority only).

In the event of a clinical need for telephone guidance such as first aid or aiding the delivery of a child, AMPDS has step by step guidance for telephone support that is appropriate for the clinical scenario. This advice is routinely provided across a range of conditions and is audited on a regular basis to ensure compliance.

In the event of a deterioration or clinical concern identified by the non-clinical emergency medical dispatcher (EMD) the EMAS dispatch protocols have in place two systems of support and safety netting. A "help card" system enables a team leader to support a call process and escalate to a clinically trained member of the team.

If it is identified that the priority allocated by the system is incorrect, for example, in cases such as a potential sepsis or antepartum haemorrhage there is a process of escalation via the EMD team leader to a clinician based within the EOC. This is recorded in the electronic records and a paper slip is produced as a part of this handover process in each case.

Our Dispatch Officers are then enabled to update our clinicians en route to patients, of any significant changes. The application of any update is time related and is contained within a dynamic risk assessment framework to ensure that the passing of information is only performed when it is required and does not cause delay the ambulance crews.

To ensure a more timely and objective Trust approach to community obstetric support EMAS has developed a standardised minimum criteria for requesting support from a remote service and from an on scene clinician. This is expected to be implemented in May 2018 subjected to governance processes. As an interim measure, guidance has been issued by clinical bulletin and to all relevant EOC staff.

Point Two:
EMAS recognises the importance of good communication and information sharing in relation to the delivery of high quality care and patient safety. As such EMAS will now implement a communication framework to ensure the provision of good quality clinical handovers, the SBAR model. The SBAR model (standing for: Situation, Background, Assessment, Recommendation) is a structured communication tool that is considered a best practice element in healthcare settings and has been

in use within EMAS for a number of years as a generic method for communication. To enhance this, EMAS have enhanced the tool to include maternity specific guidance. This structured approach will provide an outline for standardising the quality of clinical communications in a maternity specific scenario.

With regards to the specific concerns identified by HM Coroner's inquest we are also working with our obstetric service partners to extend the SBAR to create a maternity specific model. This approach has been formally shared with our network partners through the East Midlands Maternity

Clinical Advisory Group following a debate in early March 2018, in draft format for agreement as a standardised regional handover tool. This is planned for implementation across the EMAS footprint in May 2018 subject to governance approval.

In order to address the issue for units outside of the East Midlands region, we have arranged to meet with the various providers to explore working partnerships and inform them of our revised handover and communication processes.

Point three:
As a part of the engagement with our maternity receiving units, EMAS is working to promote the use of recorded facilities to complement EMAS' recording ability. Each receiving unit has been requested to ensure that the relevant clinical advice line is recorded to enable analysis of call data to facilitate any necessary learning.

Additionally EMAS is exploring the expansion of our recording ability to include remote clinician carried devices. This has been incorporated into a wider IT infrastructure plan as it has significant financial and technical implications.

In order to ensure that our clinicians are supported in making safe and effective clinical decisions we have provided all clinical staff with clinical guideline books and have commissioned an electronic app version to launch in April 2018. Further support is enabled remotely through our Clinical Assessment Team, which includes Nurses, Paramedics and Midwives.

With specific regard to the call contact being prematurely ceased, all clinical staff have been reminded of the importance of escalating advice call failings to ensure appropriate advice and support is obtained .

EMAS acknowledges its responsibility to enact a duty of care to all patients.

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

Yours sincerely

Richard Henderson
Chief Executive