London Ambulance Service NHS
NHS Trust

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[redacted]

Mr Jonathan Landau
HM Assistant Coroner for Greater London South
Croydon Coroner's Court
2, Davis House
Robert Street
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22 June 2022

Dear Sir

Regulation 28; Prevention of Future Deaths Report (PFD) arising from the inquest into the death of Raphael Jeffery GILL

Thank you for your Regulation 28 Report dated 27 April 2022, setting out your concerns to be addressed.

I would like to begin by expressing my deepest condolences to the family of Mr Gill on their loss.

The concerns set out in your PFD report were that Mr Gill was not transferred to the hospital under emergency conditions (blue lights and sirens) on 11 December 2019. You further highlight that the more senior clinician (the paramedic) drove the ambulance to the hospital while their Emergency Medical Technician (EMT) colleague attended to Mr Gill in the rear of the ambulance. You advised that the jury found that the ambulance clinicians were unaware that the combination of seizures and cocaine represented a medical emergency. In addition, you have highlighted that you found that the fact Mr Gill was under arrest by police unduly influenced the assessment of urgency.

I requested that an 'end to end' review of this case be undertaken. Following this, our Chief Paramedic, Chief Medical Officer, Director of Corporate Services, and Consultant Paramedic have completed this review and the findings were presented to the private session in Trust Board on 31 May 2022. This review has been used to inform our response.

I will set out the LAS response to these as follows:

Decision not to convey Mr Gill to hospital under emergency conditions

On arrival of the ambulance, Mr Gill presented with an increased heart rate of 127 beats per minute, an increased respiratory rate of 28 breaths per minute, and a slightly elevated blood pressure at 157/82. This would equate to a NEWS 2 (National Early Warning Score Second Edition) of five. This would put the patient in medium risk stratification using the NEWS score. The NEWS 2 score is a nationally validated tool for assessing clinical acuity and has been evaluated empirically for use pre-hospital. Mr Gill's physiological observations improved en route to hospital providing some clinical reassurance.

Mr Gill remained fully conscious while with the LAS. The police had reported that Mr Gill had four episodes of seizure-like activity with his arm and legs going stiff whilst he was in the police car, each lasting around one minute before the arrival of the LAS, there is no evidence recorded of tongue biting or incontinence, both of which are often seen in tonic-clonic seizures. It appears from the police statements that Mr Gill recovered between each of these events. The ambulance clinicians describe Mr Gill as having episodes of muscular rigidity while in their care, but he remained alert and talking. Mr Gill denied taking cocaine that day but reported having previously consumed cocaine the day before. Mr Gill had a history of seizure activity but was not routinely medicated for this.

The history of recurrent seizure type activity is clinically concerning. The recovery between seizures indicates that this was not a continual or status seizure[1].

Mr Gill was appropriately assessed and promptly conveyed to the local emergency department. We have considered carefully if a pre-alert call (blue lights and sirens) was required. On balance, there is no absolute indication that a pre-alert call was required. Mr Gill was fully conscious and able to walk himself into the hospital. The time from the arrival of the conveying ambulance on the scene to leaving the scene for the hospital was 18 minutes; this is rapid and, on balance, could not have been quicker. Therefore, the LAS believes that this does not reflect a lack of urgency, that the time spent on the scene was not excessive and it does not follow that the fact Mr Gill was under arrest influenced the timeliness or appropriateness of his assessment, management or of his care.

The decision to place a pre-alert call has to sit with the clinicians attending to the patient. To provide a definitive list of circumstances where a pre-alert call is mandated would produce a document of such length and complexity that its day-to-day use would be close to impossible. It would have to cover many a multitude of medical and traumatic conditions and patient presentations. Where a patient is fully conscious and has clinical observations within the medium NEWS2 risk stratification, we would hold that a pre-alert call would not be mandated. It is worth noting that pre-alert calls have to be balanced. Their overuse can adversely affect clinical safety within an Emergency Department, as they will distract from the routine assessment of patients waiting to be assessed as well there is a balance of risk to be struck around driving under emergency conditions. The LAS continues to work with Emergency Departments across the Capital to ensure patients are handed over and assessed promptly upon their arrival. On Mr Gill's arrival, I note that a handover was provided to clinical staff within the department, which included a copy of the LAS clinical record containing Mr Gill's clinical observation.

<u>Primacy of care</u>

The LAS recognises that the paramedic drove the ambulance to the hospital while her clinically more junior, non-registered colleague remained in the back of the ambulance attending to Mr Gill. On balance, despite Mr Gill being fully conscious, there was a history of abnormal muscle rigidity and possible seizure activity. As such, we would be of the view that the paramedic should have attended to Mr Gill in the rear of the ambulance as they would have been immediately available in the case of deterioration. As you will be aware from the documentation provided to you at the close of the inquest, the LAS has a number of guidance notices and policies around the primacy of care. In addition, there is helpful documentation from the professional regulator on this subject. We have undertaken to review the guidance we have in place and to see if we can make it more accessible by providing examples as to when we would expect a paramedic to travel directly attending to the patient.

[1] Brophy, Gretchen M., et al. Guidelines for the evaluation and management of status epilepticus. Neurocritical care 17.1 (2012): 3-23 PMID: 22528274

Patients under the influence of cocaine

Whilst we note that there was no undue delay on the scene once the conveying ambulance had arrived, we are aware that your view is that the clinicians were unaware that seizures on the background of cocaine use may present a marked clinical concern. Our Consultant Paramedic has reviewed the guidance within the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Guidelines and is of the view that these contain a detailed set of guidelines for the management of patients who have used cocaine and seizure activity is specifically detailed. Our Chief Medical Officer will share your PFD report with the Chair of the JRCALC to allow for consideration of further review of the guidance.

In terms of the LAS, we will produce an internal clinical refresher for all frontline clinicians, which will be shared in our internal 'Clinical Update' publication around the risks associated with cocaine to continue highlighting the 'red flag' presentations in respect of patients who have used cocaine. This is planned to be published in early Autumn 2022.

I hope our response assures that the LAS has robustly reviewed the care provided to Mr Gill and will continue to take actions where learning has been identified.

Yours faithfully

Chief Executive, London Ambulance Service NHS Trust