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Coroner Mary Hassell
HM Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
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13 July 2017

Dear Ms Hassell

Regulation 28; Prevention of Future Deaths Report arising from the inquest into the death of Nasar AHMED

Thank you for your Regulation 28 Report dated 21 April 2017 bringing to my attention matters of concern.

As there had been no concerns raised with the London Ambulance Service NHS Trust (LAS) prior to the inquest we were surprised and disappointed to receive this Regulation 28 Report.

I note the concern raised is stated as follows:

While staff at Nasar's school were waiting for an ambulance, they asked for advice from the call operator about whether to administer his EpiPen. They were put through to a paramedic, who advised not to use it, I think because the classic signs of anaphylaxis were not obvious.

It is unfortunate that LAS were not made an Interested Person for the inquest and as a result we did not receive the benefit of full disclosure of documents. LAS were also not asked to provide any information or documents relating to call handling or to confirm what advice had been given by the Clinical Hub paramedic nor were we informed of any concerns in this respect.

Had we been given this opportunity we would have been able to provide you with the necessary information and we would also have offered the court a senior clinician to provide evidence at the inquest to clarify exactly what advice was given by the Clinical Hub paramedic and why, which I believe would have been of benefit to the court and Nasar's family in the circumstances.

Please find attached a transcript of the call CAD 2463 from 10th November 2016.

It is clearly documented in the transcript that the caller from Bow school was unable to provide to both the LAS call handler and the Clinical Hub paramedic details as to what Nasar's clinical condition was.

Page 2 of the transcript confirms that the caller informed the call handler that they had an EpiPen and it had just been used.

The call handler repeatedly asks the caller to advise what Nasar's condition is and the caller is unable to provide clear details on whether he had allergies or asthma. As a result the call handler correctly seeks the assistance of a paramedic on the Clinical Hub, as call handlers are not clinicians. The handover from the call handler to the Clinical Hub paramedic detailed on page 4 of the transcript, details the call handler explaining to

the Clinical Hub paramedic that the caller is not able to say what Nasar's condition is and that they are requesting advice on the use of the EpiPen.

On page 5 you will note that the paramedic takes the caller through a series of questions to determine with as much clarity as is possible when one is not on scene with the patient, what Nasar's history was and his clinical presentation at that time.

At no point does the paramedic advise the caller not to use an EpiPen.

The conversation between the caller and the Clinical Hub paramedic lasts for less than one minute and before the Clinical Hub paramedic had finished asking the necessary questions, the ambulance crew arrived on scene and the Clinical Hub paramedic correctly left Nasar in the care of the on scene crew.

I note from the Regulation 28 Report that the opinion given by the respiratory paediatrician who gave evidence at the inquest was that the correct and potentially lifesaving course of action, regardless of the particular constellation of signs and symptoms, is to use the EpiPen and to use it immediately.

Given that the Clinical Hub paramedic was not clear on Nasar's condition or when Nasar had last had the EpiPen, if at all, it was not unreasonable for the Clinical Hub paramedic to spend a few moments trying to establish the facts. The process of eliciting the necessary information was almost concurrent with the first paramedic arriving on scene.

The audio recording of the inquest has been listened to by our Legal Services Department and I am advised that the evidence of the staff at Bow School was that they asked the LAS (call handler and Clinical Hub paramedic) if they should give the EpiPen but they did not get an answer. This is rather different to being told not to use an EpiPen, which was not the advice given by LAS.

It is our conclusion that the call was appropriately managed by the call handler in trying to elicit the necessary information and it is clear from the transcript provided to you that the Clinical Hub paramedic did not advise Bow School not to use the EpiPen.

I hope that this reply will be helpful in clarifying the confusion over the advice given by the LAS on the use of the EpiPen. On the basis of the reasoning set out in this response, LAS propose to take no action in respect of the concern raised in the Regulation 28 Report.

This Regulation 28 response will be shared with the Association of Ambulance Chief Executives and the National Ambulance Service Medical Directors.

Finally in closing, I should like to offer my sincere condolences to Nasar's family.

Yours sincerely

Chief Executive Officer