NHS
South Western
Ambulance Service
NHS Foundation Trust

Trust Headquarters
Abbey Court
Eagle Way
Exeter
Devon
EX2 7HY

[redacted]
Website: www.swast.nhs.uk

[redacted]

4 June 2024

HM Assistant Coroner, Dr Simon Fox, KC
The Coroner's Court
Old Weston Road
Flax Bourton
BS48 1UL

Dear Dr Fox

Prevention for future deaths report touching on the death of Romeo Esposito

I write in connection with your enquires touching on the tragic death of Romeo Esposito and in response to the Prevention for Future Deaths report issued to South Western Ambulance Service NHS Foundation Trust (SWASFT) on 15 March 2024.

I was extremely saddened to hear of Romeo's death and understand that the circumstances surrounding his death would have been extremely distressing for his family. I would like to take this opportunity to offer my personal and sincere condolences to Romeo's family and to provide reassurance that a significant amount of work has been undertaken to ensure any learning identified is embedded across the organisation.

As outlined in the report, HM Coroner has identified the following principal concerns, which I have sought to address below:

- Romeo was making respiratory efforts for about an hour after ROLE (recognition of life extinct) at 09.52 and resuscitation resumed at 10.49.
- His family raised concerns regarding this with SWASFT staff on a number of occasions throughout this period.
- Staff repeatedly ascribed this respiratory effort to a 'release of air' as opposed to a change in Romeo's clinical condition, which required further clinical assessment.
- There was no evidence to confirm that clinical staff have been warned or trained not to use 'release of air' as an explanation for respiratory effort or reason to avoid further clinical assessment.

Following Romeo's death, the Trust undertook a comprehensive review of the circumstances surrounding his death. This was done with a view to establishing a clear

chronology of events but also to elicit any learning which can be used to inform service improvement.

By way of context, a 999 call was received at 08.42 during which it was reported that Romeo was sadly not breathing and not conscious. Cardiopulmonary resuscitation (CPR) instruction was provided over the telephone whilst resources were allocated to help Romeo. Following the arrival of resources on scene, advanced life support (ALS) commenced and continued for around an hour, compared with the recommended 20 minutes as per guidance. The senior clinician on scene, who had not detected any signs of life, and in recognition of the fact that Romeo had been in cardiac arrest for more than 75 minutes, made the decision to cease resuscitation at 09.50 with ROLE confirmed at 09.52.

During the review undertaken by the Trust, it was clear that everyone on scene had worked tirelessly to save Romeo; however, some learning points were identified. This included revisiting the Confirmation of Death guidance contained within the Cardiac Arrest guidelines, specifically the amount of time that should be given between ceasing resuscitation and confirmation of death (COD). At the time of Romeo's death the guidance in place required the clinician to observe the patient for five minutes between ceasing resuscitation and COD. Allowing sufficient time between ceasing resuscitation and confirming ROLE allows the attending clinician to fully assess whether there are any signs of life indicating resuscitation should be resumed. This was subsequently revised to 'a few minutes'. As a result of Romeo's case, the Confirmation of Death guidance has now been revised to reflect that there should be at least 5 minutes between ceasing resuscitation and COD being declared, as opposed to the previous ambiguous reference to a 'few minutes'. A copy of the new guidance has been appended to this letter for reference.

The aim is for the new guideline to be live on the Trust's JRCALC clinical app by the week ending 7 June 2024. This is an app that can be accessed by all Trust members of staff as well as those contracted to work on behalf of SWASFT. In addition, once confirmation has been received that the guideline is ready to be published, a Clinical Notice alerting staff to the revisions will be issued to all staff via email and as a pop-up on the app prompting them to review the change. Once an individual has accessed the guidance, they are prompted to press a button to acknowledge the change, allowing the Trust the functionality to monitor how many Trust staff acknowledge it, which in turn provides assurance around the number of staff reviewing updated guidance.

Furthermore, during the review and in communications with Romeo's family, it was identified that following the initial confirmation of death at 09.52, members of Romeo's family alerted staff on several occasions to Romeo making a gasping sound. The response provided by staff suggested this was a normal presentation following death with no senior clinical review requested. In terms of the release of air or gasping sound described by Romeo's family, it is not uncommon to see a few gasping breaths after death. This is because the brainstem at the base of the brain, which controls respiration will continue to work for a brief period of time after the heart has stopped or after a period of CPR. It is not possible to diagnose death until this activity has stopped. If it persists beyond 5 minutes, this is potentially an indicator of signs of life mandating review by a senior clinician.

As part of the mandatory training delivered to all Trust staff for 2024 to 2025, a session on advanced life support (ALS) is to be provided. This includes a simulation around cardiac arrest management in conjunction with discussion-based learning around actions that may be required following COD. This includes the potential for a change in clinical presentation with an emphasis on this being escalated for senior review. In this scenario, the guidance dictates that in these circumstances the lead clinician must observe and reassess the patient to satisfy themselves that COD is appropriate. If any uncertainty remains, the Resuscitation Advice Line can be contacted.. The Major Trauma and Resuscitation Advice Line is staffed by experienced Specialist Critical Care Practitioners supported by a duty Consultant. The team are available to offer advice to ambulance crews 24/7. The aim is for 85% of Trust staff to have completed this training by the end of 2025, accounting for any absences attributable to maternity, paternity and sick leave.

The Trust is also launching education around how to escalate concerns using the I am Concerned, I am Uncomfortable, this is a Safety issue and Stop (CUSS) communication tool. CUSS is a technique that uses a graded assertiveness approach to communicating. Should someone be concerned with a process or intervention being put in place, they can raise concerns, becoming more assertive if they feel their concerns are not listened to. The key to this education is further training on how individuals and teams acknowledge and take steps to act on concerns raised.

In conclusion, I hope Romeo's family, with whom the Trust continues to work, and HM Coroner will be assured by the steps taken by the Trust to address the concerns raised within the Prevention for Future Deaths report.

Yours sincerely

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Chief Executive Officer

Enc:
1. Confirmation of Death guidelines