Association of Ambulance Chief Executives
25 Farringdon Street
London
EC4A 4AB

T: [redacted]
E: [redacted]

12th August 2024

BY EMAIL: [redacted]

HM Area of Buckinghamshire
Senior Coroner Crispin Giles Butler

Dear Mr Butler

FERN FOSTER (DECEASED)

I am writing in response to the preventing future deaths report we received at the Association of Ambulance Chief Executives (AACE) dated 7th June 2024, and I respond as the Director of Operational Development and Quality Improvement on behalf of the AACE and NASMeD (National Ambulance Service Medical Directors group). On behalf of AACE and NASMeD, I would also like to extend our sincere condolences to the family of Fern.

It may be helpful for us to explain that AACE is a private company owned by the English and Welsh NHS ambulance services. Its purpose is to support its members, UK NHS ambulance services, in the implementation of national agreed policy and to act as an interface, where appropriate at a national level, between them and their stakeholders. It is a company owned by NHS organisations and possesses the intellectual property rights of the Joint Royal Colleges Ambulance Liaison Committee UK ambulance service clinical practice guidelines (the "JRCALC guidelines"). AACE is not constituted to mandate or instruct ambulance services however it has national influence via the regular meetings of ambulance chief executives and chairs along with a network of national specialist sub-groups. NASMeD is one of our national director groups, and its members are the medical directors of the English and Welsh NHS ambulance services. The purpose of NASMeD is to improve clinical safety and quality of care by reducing unwarranted variation, sharing best practice, leading clinical research across the NHS ambulance services and overseeing the development of the JRCALC clinical practice guidelines.

We note the other relevant organisations named in this PFD report, namely:

- NHS England (NHS Pathways),
- National ambulance resilience unit (NARU)
- National Coding Group (Central Ambulance Team),
- Emergency Call Prioritisation Group (ECPAG)

With regard to your first matter of concern:

The process for triaging and prioritising ambulance attendance to an incident involving the suspected ingestion of sodium nitrate or sodium nitrite (intentionally or otherwise) does not provide sufficient opportunity for travel, attendance, conveyance to hospital for emergency treatment and/or provision of antidote treatment at scene, which may provide the only likely means of prevention of death where sufficient quantity has been ingested.

The process for triaging and prioritising ambulance attendance is not within the remit of AACE or NASMeD. The categorisation of 999 calls is overseen at a national level through the NHS England clinical coding group which reports to Emergency Call Priority Advisory Group (ECPAG). The algorithms for NHS

Pathways and Medical Priority Despatch System (MPDS) are overseen by the owners of the product. In England currently six ambulance trusts use a system called MPDS and the other four use NHS pathways.

With regards to your second matter of concern:

The carrying by ambulance services of appropriate antidote medication for on-scene administration (such as Methylene Blue), whilst trialled elsewhere, is not part of regional or national protocol. Swift access to this in circumstances where sodium nitrate or sodium nitrite ingestion is suspected, and timings mitigate against survival by the time of arrival at the nearest Emergency Department, could prevent future deaths in some cases.

Firstly, it must be noted that neither AACE or NASMeD has the authority to mandate the carriage of any specific drugs, including antidotes, by NHS Ambulance Services. The decision as to which drugs each ambulance service carries is made by that individual NHS ambulance Trust, authorised by the Medical Director.

We have considered whether to recommend that ambulance services carry a specific antidote to sodium nitrate/nitrite poisoning such as methylene blue, and whether to include this in our JRCALC guidance. We have liaised with a number of our partners and have come to a decision that it is not appropriate to recommend that all ambulances carry the antidote, nor that all paramedics should be trained in its use or included in our JRCALC guidance.

We are currently reviewing and updating our overdose and poisoning JRCALC guidance for paramedics, and we will be including sodium nitrate/nitrite poisoning as an example of a chemical that can be ingested. The guidance will recommend that paramedics consult the National Poisons Information Service (NPIS) database (TOXBASE) and where necessary use the NPIS 24-hour, seven-day telephone advice line for details of the effects of specific substances and advice around possible toxic doses. Where a potentially or immediately life threatening substance has been taken, rapid conveyance to hospital will be recommended.

We have liaised with and specifically asked for an expert opinion from the National Poisons Information Service. The response we received was that there is currently no evidence to recommend the routine carrying of methylene blue antidote by ambulances. They felt that more studies and evidence is required. They suggested the approach should be for paramedics to immediately administer 100% O2 and then rapidly transfer the patient to an emergency department ready to assess and manage the patient.

We are aware of a trial of the use of methylene blue in West Midlands ambulance service by HART (Hazardous Area Response team) paramedics. These paramedics have received additional training and respond to incidents including industrial accidents and chemical exposures. HART teams also carry specialist oximeter devices that are needed to recognise abnormal haemoglobins such as MetHb, which can occur as a result of sodium nitrate/nitrite poisoning. We are aware that NARU will be convening a clinical sub group meeting to gather insight into advances in clinical practice for HART paramedics and share information on clinical practice and that the management of toxicological incidents and subject matter experts will be invited to contribute to the discussions. The proposed agenda will include the management of sodium nitrite/nitrate poisoning with the potential role of methylene blue within HART practice and will include a presentation from West Midlands ambulance service of their experience of using methylene blue. We anticipate the outcome of this meeting will be fed back to us, so that we can look to support and improve clinical practice within all ambulance services. One outcome may be to expand the trials of use of methylene blue by HART paramedics and to gather more evidence of its use. We will also continue our liaison with NPIS.

It must also be noted that JRCALC have been named as an interested party into the forthcoming inquest of another tragic death from sodium nitrate poisoning. We will continue to do everything possible to be aware of specific poisoning cases and liaise with partners including the coronial system, particularly where there may be an increased incidence, so that we can continue to review our clinical guidance and consider the need for changes to our current clinical guidance.

I hope this response has adequately addressed the concerns that you have raised. If you have any further questions, please do not hesitate to get in touch.

Yours sincerely

Director of Operational Development and Quality Improvement