London Ambulance Service NHS Trust

**Legal Services**
Headquarters
220 Waterloo Road
London
SE1 8SD

Tel: [redacted]
Fax: [redacted]

www.londonambulance.nhs.uk

His Honour Judge Lucraft QC

Our Ref: 6226
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Dear His Honour Judge Lucraft QC,

**RE: Fishmongers Hall Inquests - LAS Regulation 28 Submissions**

Thank you for the opportunity to respond to the submissions made in relation to potential areas for a report to prevent future deaths in accordance with Regulation 28 of the Coroners Rules.

The London Ambulance Service NHS Trust ('LAS') will respond to the submissions made which may affect the services we provide.

The LAS is very grateful for the thorough inquest, and professional approach taken by all of the advocates to the witnesses at the inquest hearings. The LAS emergency responders did find attending the hearings very stressful, but of course they were pleased that they were able to assist the jury to understand their actions on the tragic day in question. Those emergency responders were very touched by the comments made by the jury after the conclusions were reached.

**A report to Prevent Future Deaths**

Under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person the s/he believes may have the power to take such action. The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future.

The Chief Coroner's Guidance Number 5 states[1];

> *"A coroner may shed light on a system failure that has regional or even national implications. However, coroners should not be drawn into reporting about matters that have not been explored properly at inquest (or investigation). It is not a sufficient basis for a PFD simply because it occurs to the coroner or an interested person that a certain matter might benefit from consideration, if it has not been at all germane to the death under investigation."*

[1] paragraph 21

**Communication between the emergency services**

It has been submitted that the evidence heard at the inquest gives rise to a concern about an 'apparent lack of structured communication between the first responders on scene'. The LAS does not agree that this is the case. The numerous methods and structures in place for communication during a major incident were not explored in detailed evidence at this inquest, nor did the wider investigation reveal such a concern. There was no evidence of a deficiency or omission in communication of the decision to the LAS responders on scene. The evidence at this inquest indicated that when a decision had been made to declare the area a 'warm zone' and so to allow entry by appropriate responders, the LAS tactical response unit was already on scene and were informed within a reasonable time.

It has been submitted that perhaps 'structured systems and guidance in relation to communication between responders at all areas of a major incident could help …'. The LAS agrees that communication is one of the key aspects of responding to marauding terrorist attack or other major incidents. The LAS submits that the appropriate policy, structure, and training is already in place and jointly operated between the emergency services. The relevant polices (including joint operating procedures) were disclosed in advance of the inquest.

As a result, in this case, the LAS submits that it would not be appropriate for the Coroner to issue a 'recommendation' to revise policy in relation to communications on scene at a major incident.

**Marauding Terrorist Attack and Triage**

It has been submitted that 'a recommendation' should be made to 'assess and revise guidance or training in relation to the steps to be taken when using the modified triage system in a major incident including information to be obtained by the medical responder at the scene'.

There was no suggestion in the evidence heard at this inquest (or during the investigation) on which there can be grounds to be concerned about a risk of future deaths occurring in relation to the clinical triage. There was no evidence of any deficiency or omission in relation to the triage decision-making process, which followed the appropriate policy. Nor was there a suggestion that there was a problem with the policy itself which might create a risk of deaths in the future. The process and policy was not explored in detail at this inquest.

There often are differences in the accounts and timings provided by those on scene, particularly in highly pressurised situations. The LAS agrees that lay people and others may well also be suffering from trauma and shock, and may not provide an accurate or reliable account. As a result, the LAS policy and training does not rely on such information.

In this case, the crucial clinical considerations for the Paramedic and the air ambulance doctor was not the background information. It was:

1. the defibrillator machine which was already in use, which had not advised that a shock be given, and
2. the absence of any signs of life at the time of the triage assessment.

To the qualified paramedic, this clinical information correctly indicated that the patient had sadly died. There was no electrical activity in the heart that would be amenable to a shock i.e. there was no treatment which could be given to re-start the heart.

The LAS appreciates the suggestion in relation to warm-zone triage, and can understand the intention with which it is made. However, the LAS cannot agree that 'a checklist of questions' to ask non-qualified people on scene, would assist qualified paramedics making such triage decisions during a major incident, whilst in a warm zone. The LAS, having considered this, are clear that this would not aid in the clinical decision making and would be likely to create delay whilst in a warm zone (where quick decisions are vital).

**Conclusion**

In conclusion, the LAS submits that there are no circumstances in this case, which give rise to a concern about a risk of future deaths in relation to LAS policy. As a result, a report to prevent future deaths based on the evidence in investigation and inquest would not be appropriate.

However, as per our witness statements (both operational and clinical), the LAS continues to assess their policies and procedures for major incidents, and to actively join learning events and strives for continuous improvement, along with their emergency service colleagues.

Yours sincerely

[redacted]

**Khadir Meer**
Chief Operating Officer and Deputy Chief Executive

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**Dr Fenella Wrigley**
Chief Medical Officer and Emergency Medicine Consultant