London Ambulance Service NHS
NHS Trust

The Rt. Hon Lady Justice Hallett DBE
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Dear Lady Justice Hallett

London Ambulance Service response to the Report under Rule 43 of the Coroners Rules 1984: London Bombings of 7th July 2005

Following the inquests into the deaths of the 52 members of the public on 7th July 2005 and your subsequent Rule 43 Report dated 6th May 2011, I write to advise you of the actions that the London Ambulance Service NHS Trust will be taking in regards to the recommendations made to us and to address other relevant issues contained within your report.

There was one specific recommendation made in regards to our Trust. This was recommendation 8 and set out *"I recommend that the LAS, together with the Barts and London NHS Trust (on behalf of the LAA) review existing training in relation to multi casualty triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention"*.

In addition, there were a number of areas in the report where you made reference to a desire for wider consideration, although you did not make formal recommendations in regards of these. I will discuss each of these in turn in this response so that you are aware of the actions we have taken or are planning to take.

Recommendation 8: Review existing training in relation to multi casualty triage

We have considered this recommendation as part of a wider review of the triage process in multi casualty situations and have formed a group within the Trust to address matters associated with this. The working group also has two senior clinicians from London's Air Ambulance as part of its membership.

A workshop was held on 1st June, when the issues of triage sieve and sort were discussed in the context of needing to ensure basic interventions such as airway management and haemorrhage control takes place at the same time as the triage process begins. This

workshop took place after a series of internal and external discussions to agree the best way of approaching these actions.

As a result of the work of this multi-disciplinary group, we have agreed a series of actions based on their recommendations. These are detailed in an action plan that will drive and track the recommendations. The recommendations also include a refresher training programme to be delivered over 24 months to all frontline staff, access to an e-learning programme for all frontline staff which will also made available to partner agencies and also refresher training ahead of major planned events as part of each individual event briefing. The group also discussed and agreed that the existing triage sieve is fit for purpose. The possibility of adding in a pulse check was discussed, however it was felt that this is an unreliable clinical sign and has a high false positive rate, even when performed by experienced clinicians. The group therefore recommended that the triage sieve will now include looking for signs of life.

In addition we have agreed that basic life saving interventions are appropriate and may reduce suffering. These will be undertaken at the time of triage sieve and include basic airway manoeuvres and the use of airway adjuncts, together with the use of the recovery position.

The group further agreed the use of tourniquets or pressure dressings in the event of catastrophic haemorrhage.

Where indicated, the use of pain relief in an easily administrable form was also recommended to reduce suffering for patients awaiting removal from the scene. There is one area in particular where we would value your support, and that is around the opportunity for staff to be able to carry pre-filled doses of morphine to be available for immediate use in treating patients, in the same way that armed forces personnel in combat situations overseas have it available to treat themselves or their colleagues.

We are in ongoing discussions on this issue with the Home Office, but would welcome any support that you could give in this regard.

Use of plain English

During the course of the inquests and in your subsequent report, concern was expressed that emergency services use too much “jargon” and therefore make it more difficult for other services and agencies to support any response to an incident.

I recognise that we have a number of acronyms and abbreviations that we use daily and, whilst they do make sense to our staff, they may not help others.

You will be aware that we delayed the publication of our revised major incident plan so that we could incorporate any new lessons identified as a result of the inquests. The revised major incident plan will include the changes set out above in relation to the triage process and, where possible, we will also remove anything that we think could be considered as jargon. You will appreciate that it is not possible to completely remove such terms as many

of them help to speed up communication; however, we have done what we can to address this issue and will continue with these efforts in other Trust policies and procedures.

Recording of the administration of medicines at the scene of a major incident

This is a more difficult issue to address in the multi casualty scenario, but is nonetheless one that we have begun to tackle.

The triage card that we currently use is not intended for the recording of extensive treatments at the scene of a major incident, as it is small and contains sufficient space to record basic patient observations only. Our staff normally record extensive treatment details on the full patient record form (now introduced as a requirement for all patients involved in a major incident in our revised and soon to be published major incident plan). This requirement was not in place in July 2005.

However, the group unanimously supported that the training around triage must emphasise the importance of focused contemporaneous documentation to allow appropriate ongoing care and that all triage notes MUST remain with the patient and be handed over to the Hospital.

Every patient must have a patient record completed and a shortened record form, which is already available, will be used.

Covering of deceased people

We have considered this issue in terms of patient dignity, operational need, scene clearance and scenes of crime management in relation to the preservation of evidence. We have consulted with colleagues from London's Air Ambulance and other ambulance trusts around the country and have concluded that:

1. Where a deceased person is identified at the scene of a major incident and is not in public view or that of the media, the body will be assessed for signs of life, appropriately triage tagged (marked) and left uncovered.
2. Where a deceased person is identified at the scene of a major incident and is in public view or that of the media, the body will be assessed for signs of life, appropriately triage tagged (marked) by staff from London Ambulance Service NHS Trust and London Air Ambulance in order to allow due attention for forensic processes.
3. In the event of a body at the scene of a major incident being covered and not having a visible triage tag or marking, identifying the fact that a clinical assessment has taken place, such an assessment will take place immediately.

These arrangements will be detailed in our revised major incident plan that will be published shortly.

We have shared these changes with colleagues around the country at a national lessons identified event for UK ambulance services held earlier in June.

First aid training in the community

I am pleased that you recognised in your report the efforts we have made to train members of the public in basic first aid and resuscitation skills. In some of these sessions, we are also now including familiarisation training in the use of defibrillators – devices which are used to shock a person's heart to restart it. Our public access defibrillator campaign, run in conjunction with the British Heart Foundation, has now placed 570 defibrillators in public places such as underground stations, theatres and public buildings across London. We have trained over 6,600 members of the public to use these life-saving machines as, where these are used in conjunction with bystander resuscitation, the survival rate is significantly higher than normal.

In addition, since 2003 we have trained 64,000 members of the public in skills to deliver bystander resuscitation and basic life support.

We will continue to deliver this programme of important community engagement activity that evidence shows saves lives and we welcome your support for the programme.

Multi-agency training and recommendations directed at the London Resilience Team

You will be aware that the London Resilience Team, chaired by the Deputy Mayor of London, has met to consider the recommendations you directed at multi-agency partners.

We fully support the actions to be taken to address these points, as outlined in the London Resilience Team's response to you.

In conclusion, we have started to take action to address the recommendation you made specifically to the London Ambulance Service NHS Trust, together with those issues where concern was expressed within your report. Many of these actions are now complete and for those that are not, they will be managed through our action plan which will be overseen and reviewed by our senior management group on a monthly basis until complete.

I hope that this response helps to assure you of our commitment to continue to develop our plans to respond to future major incidents

Yours sincerely

Peter Bradley CBE

Chief Executive Officer