A Royal Undertaking

Dr. Fionna Moore

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The Influence of Her Majesty’s Coroners on EMS in England & Wales
The Coronial System

In place since 11th Century

• Formally established in 1194 to ‘keep the pleas of the crown’ (custos placitorum coronae)

• Treasure trove
The Coroner

- Independent of the NHS
- Required to be legally or medically qualified.
- Some dually qualified and full time
- Second in seniority only to Courts of Appeal Judges
- Highly influential
**Jurisdiction of HM Coroner**

To establish:

- Who the deceased was
- How, when and where they came about their death
- A conclusion is reached and the Coroner records the details required for the registration of the death. It is not the function of an inquest to determine any question of civil or criminal liability on the part of a named person.
Within England and Wales

(Procurator Fiscal in Scotland)

- 125 Coroners Districts
- 8 in London
- 230,600 deaths reported to HM Coroners
- 31,000 Inquests opened

(Coroner’s Statistics 2010, Ministry of Justice)
Areas of influence

• Duty of care to flag issues

• Rule 43 Report
  364 issued April 2010-March 2011
  11 Reports to include ambulance services

- Provides Coroners with power to make a report to a person/organisation to prevent future deaths
- Organisation has 56 days to provide written response
- Response must set out actions taken
- Coroners may send a copy of the report and its response to any organisation with an interest
- The Lord Chancellor may publish a copy of the report/response
Examples of Recent Rule 43 Reports

- Ministry of Defence
  - Ensure that the filler in soldiers’ body armour is assembled correctly

- Highways Agency
  - Consider placing crash barriers around all lampposts on the M25

- National Patient Safety Agency
  - Consider issuing an alert to reduce or eliminate the risk of self harm by plastic bag suffocation
Recent Ambulance Service
Rule 43 Recommendations

• Issued to LAS and NHSD, Sept 2011: Patient referred to NHSD and later died of necrotising fasciitis post dog bite
• Recommendation: “That communication systems between LAS and NHSD are reviewed to ensure clinically important info is passed between the agencies”
• Bulletin issued to Control services staff reminded to pass all clinically important info from 999 callers
• Article published in quarterly ‘Clinical Update’ on treating open/puncture wounds
Rule 43: Sharing of Information

- Important clinical info during 999 call not passed from one Ambulance Service to another (outer counties services)
- Involved details of serious blood disorder
- Rule 43 report issued to East of England, Feb 2011
- LAS released bulletin setting out minimum info that MUST be obtained from other ambulance service
- Emphasised that call handlers must also ask: “Is there any other relevant history, including medication, relating to the patient?”
Rule 43: London bombings

• Issued 9 recommendations in May 2011 (1 for LAS).
  • Triage sieve reviewed – basic airway management and arrest of catastrophic bleeding at initial point of triage.
  • Refresher training programme being delivered to all frontline staff. Importance of triage notes remaining with patient until handover emphasised.
  • Researching possibility of pre filled morphine syringes.
Rule 43 – sharing information

- Post tonsillectomy bleed (Welsh AS)
  Communicated to all Ambulance Services
  Medical Directors for inclusion in training

- Haemorrhage from dialysis fistula
  Risk highlighted; role of CAT tourniquet
How can Ambulance Services assist the Coroner?

- Coroners are not experts in pre-hospital emergency care
- Provide information on the changing strategic direction
- Inform and explain Ambulance Service policy and procedure
## 999 Call Triage Categories

<table>
<thead>
<tr>
<th>National Key Standard</th>
<th>Locally Agreed Response Profile</th>
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</thead>
<tbody>
<tr>
<td><strong>Category A (Red Calls)</strong></td>
<td><strong>Category C Calls</strong></td>
</tr>
<tr>
<td>Red 1 (Echo codes)</td>
<td>Red 2</td>
</tr>
<tr>
<td>Respond to 75% of Category A (Life-threatening) calls within 8 minutes or less.</td>
<td>Respond to 75% of Category A (Life-threatening) calls within 8 minutes or less.</td>
</tr>
<tr>
<td>19 minute transport standard</td>
<td>19 minute transport standard</td>
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</tbody>
</table>

### MDT CODE
- RED 1
- RED 2

### Response Times
- C1 EM
- C2 EM
- C3 EM
- C4
Clinical Telephone Advice

• Lower priority (non-life threatening) calls passed to Clinical Advisors
• Enhanced clinical assessment undertaken by clinicians
• Medical advice provided/referrals to appropriate care pathways
• 13,333 calls closed with telephone advice

(April 2011-January 2012)
<table>
<thead>
<tr>
<th>Borough</th>
<th>Oral Evidence Provided</th>
<th>Records Provided</th>
<th>Statements Provided</th>
<th>TOTAL</th>
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<tbody>
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<td><strong>TOTAL</strong></td>
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<td><strong>143</strong></td>
<td><strong>1231</strong></td>
<td><strong>1347</strong></td>
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</tbody>
</table>
Wider Learning from Traumatic Deaths

293 trauma resuscitations undertaken in 1 year in London. 165 of these resuscitation attempts ceased on scene.
Trauma Aetiology - transported

Triage Tool positive patients by injury mechanism 06/04/2010 to 30/09/2010, n=1,828

- RTC: 627 (34%)
- Fall: 454 (25%)
- Stabbed: 440 (24%)
- Assault: 112 (6%)
- Unknown: 66 (4%)
- Other: 73 (4%)
- Shot: 56 (3%)

Image Description: A pie chart showing the distribution of trauma cases by injury mechanism.
Audit of West London Coroner’s Files

- Relates to 7 London Boroughs
- Population 1.6 million
- Review of 8 months of paper files (in boxes) from 2011
- All patients died at scene
Audit of West London Coroner’s Files

22 Cases Reviewed

• 2 Stabbings
• 1 Shooting (suicide)
• 7 RTCs
• 6 Falls from height (3 suicides)
• 6 People under trains (4 suicides)
Audit of West London Coroner’s Files

- 8/22 History of mental illness
- 7/22 Known history of drug or alcohol addiction
- 9/22 Not born in UK
- 2/22 Illegally in UK
- 7/22 Unemployed
- 3/22 Retired