PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

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THE LAS MUST LEARN TO LISTEN TO PATIENTS AND STAFF IN ORDER TO IMPROVE THE QUALITY AND SAFETY OF CARE THEY PROVIDE

NEZIAH'S MUM TALKS ABOUT HER TRAGIC EXPERIENCE WITH THE LONDON AMBULANCE SERVICE

IDENTIFYING SERVICE IMPROVEMENTS FOR THE LAS THAT WOULD SAVE THE LIVES OF BABIES AND ENHANCE THE CLINICAL CARE OF PREGNANT WOMEN SUFFERING CRITICAL BLEEDS, WHICH ARE INDICATIVE OF PLACENTAL ABRUPTION

PRIORITY No.1

Women suffering severe vaginal bleeding during pregnancy should always receive an emergency ambulance response within 7 minutes because this is a life-threating condition for both mother and baby.

At 5.20am on 3rd July 2015 I called the LAS. I was 27 weeks pregnant, 37 years old and had suffered severe vaginal bleeding since 5.15am. I also had cramps and a previous history of Placental Abruption and Pre-Eclampsia. This was my 3rd pregnancy.

I told the LAS that I had had a gush of blood, was suffering severe stomach pain, was very distressed and was alone with my children who were 4 and 10 years old. I was initially told that I should have a response to my 999 call within 8 minutes (maternity protocol/R2 priority).

But, instead of sending an ambulance to take me to hospital immediately, the LAS sent an FRU 'fast response unit', which arrived at 5.44am – 14 minutes after my call.

Paramedic A examined me and then called the LAS Emergency Operations Centre three times, trying to get an ambulance to take me to hospital immediately (5.58am, 6.07am, 6.26am).

The Paramedic was told by the EOC that, despite the seriousness of my condition, she would have to wait until an ambulance was available. Her diagnosis was Placental Abruption, but her Patient Report Form (PRF) disappeared before the investigation of my complaint. Placental Abruption is an obstetric emergency indicating serious risk to both mother and baby (https://tinyurl.com/w4sycdpv).

Paramedic A was told that no ambulances were available, despite my bleeding getting heavier and the passage of blood clots. She was empathetic but could not get an ambulance more quickly despite her three attempts. I believe that my baby Neziah died because no ambulance was immediately available.

I later discovered, when they told me I should have a response within 8 minutes, that this was for only 75% of patients – other critical emergencies like mine just had to wait until an ambulance could be found.

PRIORITY NO. 2
When the LAS provides emergency care for a woman suffering a severe bleed because of suspected placental abruption, paramedics should quickly establish a presumptive diagnosis, canulate the patient and take the patient straight to the nearest emergency maternity department.

The ambulance arrived at 6.31am – 61 minutes after my call, because no ambulance was available before that time. The ambulance was actually available at 6.03am but took 30 minutes to get to me – partly because staff had lost the ambulance keys, and the need to do ambulance safety checks.

Despite FRU Paramedic A handing over to the ambulance Paramedic, and the fact that I was bleeding very heavily, the ambulance crew failed to recognise that my condition - and Neziah's - were both life-threatening.

The LAS thought that it was adequate for them to achieve their R2 target by providing a vehicle capable of being with me within 19 minutes and then taking me to hospital. During the investigation the LAS seemed comfortable with that aspiration, even though they had hopelessly failed to achieve it - and actually took 61 minutes to get an ambulance to me following my 5.30am call.

I call this my baby's 'bleeding to death time'.
I last felt Neziah move at 6.10am, 41 minutes after my call to the LAS.

I had already been diagnosed by the first FRU Paramedic A as having Placental Abruption, so after handover all I needed was **immediate** transfer to King's College Hospital – 2.8 miles away - **a six-minute journey.**

The whole process of transferring my care to experts at King's seemed incredibly slow and uncaring.

PRIORITY NO.3
Where a pregnant woman has suffered a severe bleed with clots, and clinical observations have already been carried out by a FRU Paramedic, the ambulance crew should immediately transport the patient to hospital as an obstetric emergency.

Unbelievably, when the ambulance arrived with a crew of one Paramedic, one Emergency Medical Technician and one student, despite my life-threatening bleeding, they left me with the student, whilst the Paramedic B and EMT went down in the lift to get a 'carry-chair'.

They appeared to lack awareness or insight into the gravity of my condition, despite the handover from the FRU Paramedic A, making it clear that I had been bleeding and expressing clots for one hour.

They carried on wasting time by doing tests on me, which had already been done. Despite my continuous bleeding, confusion and severe pain, the ambulance Paramedics stayed in my home until 7.01am, i.e. for 30 minutes rather than taking me straight Hospital. No pain control was offered to me despite my reporting that my pain was at 8/10.

According to the LAS, staying with me for 30 minutes in my home when I was severely haemorrhaging was 'not unreasonable', because I lived on the third floor, despite the fact that they used the lift to go up and down which takes a few minutes.

I believe these decisions directly contributed to the death of Neziah.

PRIORITY NO.4
Where a patient has suffered a severe bleed, paramedics should carefully explain to the patient the importance of canulation and provided fluids to ensure that the patient is fully hydrated. This priority is in accordance with the Montgomery Ruling

Paramedic A did try to cannulate me but did not explain the reason for cannulation and I remembered an upsetting experience from a previous attempt to cannulate me. The reason was explained more clearly by Paramedic B, and I agreed to the insertion at 6.58am just before they set off to Kings at 7.01am.

However, although I was given oxygen for a fainting fit on the way to King's, the ambulance Paramedic gave me **no fluids** even though I was heavily bleeding.

In all I lost 2.2 litres of blood. Ambulance Paramedic B acted contrary to clear clinical advice on this matter (NICE accredited guidelines, produced by the Royal College of Obstetrics and Gynaecology).

The Montgomery Supreme Court Ruling

"The Doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision.

"This role will only be performed effectively if the information provided is comprehensible. The Doctor's duty is not, therefore, fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form." **https://tinyurl.com/7njszzd3**

PRIORITY NO. 5

If a pregnant woman suffers a serious bleed due to suspected placental abruption, the LAS should always call ahead as soon as possible and arrange to be met by the emergency maternity team, to ensure rapid access to treatment to save the baby's life.

We left my home at 7.01am and Paramedic B made a priority call at 7.05am allowing **two minutes** for the King's Emergency Team to respond.

We arrived at King's at 7.07am - a journey which took just 6 minutes. The Emergency Maternity Team was **not** there to meet us. I told the crew to take me the 4th floor Delivery Suite – I know King's Maternity Department very well, but they ignored me and took me to the 3rd floor.

As a result of failing to arrange for us to be met by the Emergency Team and ignoring me, a further 13 minutes was wasted while I was bleeding and desperately in need of emergency care. I was eventually handed over to the Maternity Team at 7.20am.

I can't understand why the LAS Emergency Operations Centre didn't know where the Emergency Maternity Department at King's was.

Altogether the LAS wasted 1hr/42 minutes from 5.38am when the ambulance should have arrived to 7.20am, when I was clinically handed over to the King's Midwifery Team. Even allowing for 10 minutes to take my observations and fit a cannula, and 10 minutes to get me to King's, there was still a delay of 1hr 20 minutes.

"For women with a Placental Abruption any delay to Caesarean Section reduces the probability of a successful delivery and increases the risk of maternal morbidity" (Quote from the LAS).

I strongly believe that these delays led to the tragic death of my baby Neziah.

PRIORITY NO. 6
When a pregnant woman who is bleeding is seen initially by a FRU paramedic, who then hands emergency care over to an ambulance Paramedic, there should be immediate action to get the woman to hospital, not just a repeat of the clinical tests that the FRU Paramedic had already completed. Where a patient is critically ill time is of paramount importance.

FRU Paramedic knew how serious the situation was and called the EOC 3 times.

When the ambulance arrived, they should have immediately brought up the 'carry chair' and taken me to King's. They could have done any necessary observations on the journey, including identification of Tachypnoea (fast breathing) and Tachycardia (by ECG), but the continuous bleeding with clots should have been enough to have alerted the ambulance Paramedic B to the gravity of my situation.

The Ultrasound Scan taken at King's showed that my baby Neziah was dead.

PRIORITY NO.7
The LAS should be honest when they are responsible for a death. They should apologise (Duty of Candour) and demonstrate what steps they have taken to prevent future deaths from this cause.

The LAS claimed their actions were correct in triaging my call at R2, which only required an 8-minute response for 75% of patients, but I was bleeding heavily and both Neziah's life and my life were at risk.

The LAS claimed that the long delay: "Did not negatively impact on patient outcome". Clearly, disregarding Neziah's death!

But the Clinical Adviser told the truth:

"OUR DELAY IN THE PROVISION OF AN AMBULANCE AND CONVEYANCE TO THE MATERNITY UNIT CAUSED HARM TO BOTH MOTHER AND FOETUS BY DELAYING ACCESS TO EMERGENCY CAESAREAN SECTION"
(Incident 74400 STEIS 2016/3896)

PRIORITY NO.8

UNDERSTANDING HOW I FELT – NEZIAH'S MOTHER

"Dealing with the LAS on the 3rd July, 2015, was a nightmare and 'a morning from hell'. This I would not wish on anyone. It was so distressing to overhear the response that Paramedic A got to one of her calls to the Emergency Operations Centre (EOC), to get an ambulance for me. She was met with a very rude and uncaring reply from what sounded like a very desensitised staff member. I could tell from her voice that Paramedic A was anxious about me - she knew my condition was deteriorating at speed, as I had just passed another clot almost double the size of the palm of my hand. The EOC staff member raised her voice in an aggressive manner and said: " Well she's just gonna have to wait....". This callous response sent chills down my spine and just sums up my whole experience of how the LAS emergency service operated on that tragic day.

I felt from my first call at 5.20am that my experience of the LAS was not patients-led. Neither the Paramedics attending me at home, nor did the journey to the hospital seem to be about my needs. I was not listened to. I was given false hope and the Paramedics seemed to have little understanding how my body felt at that appalling time.

It just felt as if my condition was of no real urgency to the people who were responsible for my care. It felt like they were going for a burger - they moved so slowly - and it was very disturbing to me. I could hear their conversations in the front of me whilst I struggled to breathe, and those conversations were not about me.

Despite my life-threatening condition, their conversations as Paramedics and with King's staff did not sound as if the situation was urgent, an emergency, or required fast attention. Which was why, on arrival at the hospital there were no doctors waiting for me, as on previous occasions when I had needed emergency care during a pregnancy … and why I was laying in A&E for more than 10 minutes, when every second was crucial to Neziah's survival.

I will not hide my 'gut feeling' that these people seemed careless and were going to let my baby die. I felt this on more than one occasion while I was in their care. One example being the length of time I lay in the ambulance were outside my house, considering the amount of time it had already taken them to arrive at my home.

… And to see their excuses in the Enquiry Report, of not being able to find the keys to the ambulance as someone had taken them home, and when they were calling another senior member on their radio, the calls were not answered. To me their excuses were just ludicrous. I believe the incompetence shown by the ambulance service on July 3rd, 2015 put my life at risk and killed my baby.

I was also told by the first Paramedic that my baby would be fine, and I could bring him into her ambulance base to see her. This statement came after me telling her that my baby was going to die, because the ambulance was taking too long to get to me.

It was very painful when I saw the doctor's face confirming what I had said to the Paramedic. I can never get one of the Paramedic's faces out of my head, when they wheeled me past him to go to the theatre, to remove my baby after telling me that there was no sign of life.

… And if that was not bad enough, the way I was treated when making my complaint was awful – right up until I reached out to the Ombudsman for further assistance, due to me feeling that I was not treated or cared for properly by the LAS.

As a result of their failures, I could have died, however my beautiful baby son did die.

It feels like it ended there, as the LAS were dangling many things before me. I was made to feel that they were working with me. A lot of things were offered and suggested. Some things happened and other things never surfaced, which just led me to believe that the LAS were just leading me on to think that they cared and wanted to make a difference to future situations like mine. I believe that they wanted to bide their time and reduce the risk of any process that I might have wanted to go forward with.

I believed that going to the Ombudsman for extra support would help, as I felt that my child and I were not dealt with properly and safely by the LAS. It was very sad to see the lack of integrity and transparency in the investigations that were carried out into my case.

I have been left with no baby, a very bad taste in my mouth regarding LAS emergency services, and I feel that I have not got any justice for my baby Neziah.

NEZIAH'S MOTHER

CO-PRODUCTION CHARTER AGREED BETWEEN LAS AND THE PATIENTS' FORUM – BUT NEVER IMPLEMENTED BY THE LAS

www.patientsforumlas.net/co-production-in-the-las.html

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PREVIOUS FORUM NEWSLETTERS – 2020

These can be found on www.patientsforumlas.net

NEWSLETTERS

1. **OCT 2019 – Equality and Diversity in the LAS – Safe and effective services for London's LGBTQ communities. Joseph Healy-LGBTQ Lead.**

2. **MAY 2020 – LAS Review their Patient Involvement Performance.**

3. **JUNE 2020 – "My Experience of Stroke Care in the LAS" By Courtney Grant: Forum Lead on Stroke and Human Factors.**

4. **JULY 2020 – "My Experience of the LAS – Preventing Suicide and Self-Harm" By Alexis Smith, Forum Lead on Acute Mental Illness.**

5. **AUGUST 2020 Identifying service improvement for the LAS to enhance their clinical care of patients who have epileptic seizures. Sean and Vic Hamilton – Forum leads on Epilepsy.**