Scottish Parliament Region: Glasgow

Case 200501929: Scottish Ambulance Service

Summary of Investigation

Category
Health: Ambulance, staff attitude/dignity/confidentiality

Overview
This complaint concerns the events that took place when a Scottish Ambulance crew responded to an emergency telephone call. The complainant believed that the crew behaved unprofessionally during and after their attendance at the scene.

Specific complaints and conclusions
(a) The behaviour and attitude of Officer 1 and Officer 2 towards Ms C fell short of the standards expected *(not upheld)*

(b) The Scottish Ambulance Service failed to adequately deal with Ms C's subsequent complaint about Officer 1 and Officer 2 *(upheld)*

Redress and recommendations
The Ombudsman recommends that the Scottish Ambulance Service:

(i) apologise to Ms C for their maladministration in the handling of her complaint;

(ii) review how they communicate the outcome of a complaint.

The Scottish Ambulance Service has accepted the recommendations and will act on them accordingly.

Introduction

1. On 14 October 2005 the Ombudsman received a complaint from a woman (referred to in this report as Ms C) against the Scottish Ambulance Service. Ms C complained about the behaviour of the two members of the Scottish Ambulance Service crew (referred to as Officer 1 and Officer 2) when they responded to the emergency telephone call made by Ms C's mother (referred to in this report as Mrs D) on 29 January 2004, to attend to Ms C's late father (referred to in this report as Mr D). Ms C also complained about the inadequate manner that the Scottish

Ambulance Service dealt with her subsequent complaint about the behaviour of Officer 1 and Officer 2 on 29 January 2004.

2. I have investigated Ms C's complaints that:
(a) the behaviour and attitude of Officer 1 and Officer 2 towards Ms C fell short of the standards expected;
(b) the Scottish Ambulance Service failed to adequately deal with Ms C's subsequent complaint about Officer 1 and Officer 2.

Investigation
The investigation of this complaint involved obtaining and reading all relevant documentation, including correspondence between Ms C, her lawyer (referred to in this report as L1) and the Scottish Ambulance Service. I have reviewed the Scottish Ambulance Service complaints procedure which stated:

> 'When your complaint has been fully investigated, you will receive a full response in writing, normally within 20 working days. If there are factors which influence this time-scale, we will write to you to keep you advised of any anticipated delay in concluding your complaint.'

3. I have also examined Ms C's detailed diary of events and the Scottish Ambulance Service complaint file. Included in the complaint file was the Scottish Ambulance Service Emergency Medical Dispatch Centre record of the emergency call out and written statements made by Officer 1 and Officer 2. I also met with Ms C on 14 December 2005 when she gave me a clear account of her recollection of the events of 29 January 2004 and subsequent events thereafter. A written enquiry was made of the Scottish Ambulance Service on 1 February 2006 and their response was received on 1 March 2006.

4. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked. Both Ms C and the Scottish Ambulance Service have been given the opportunity to comment on a draft of this report.

(a) The behaviour and attitude of Officer 1 and Officer 2 towards Ms C fell short of the standards expected

5. Ms C told me that the behaviour and attitude of Officer 1 and Officer 2 towards her on 29 January 2004 fell short of the professional standards she expected. Ms C told me that she felt that the care that Officer 1 and Officer 2 gave to her late father was inadequate and contributed to the worsening of her late father's medical condition.

6. In their response to me, the Scottish Ambulance Service stated that when Officer 1 and Officer 2 arrived on the scene, they spent 23 minutes delivering treatments relevant to Mr D's presenting condition and carried out their duty of care. This included monitoring Mr D's pulse, taking electro cardiographs and blood pressure readings. Subsequent investigations by the Scottish Ambulance Service failed to establish any misconduct or unprofessional behaviour by either Officer 1 or Officer 2 prior to transporting Mr D to hospital for emergency admission.

7. Ms C told me that Officer 1 and Officer 2 were allowed to defame her and her family's good name and character by reporting her to the Police for allegedly using offensive language. Ms C does not accept that.

8. In their response to me the Scottish Ambulance Service stated that as far as they had been able to establish, Officer 1 and Officer 2 were subjected to shocking and abusive language from Ms C when they approached the location of Mr D's house to attend to him. According to Officer 1 and Officer 2, when they arrived on the scene, Ms C met them with the comments, I quote, 'hurry up you f - - - - - g c - - - s' and this abuse continued from Ms C while Officer 1 and Officer 2 assessed and treated Mr D before they transferred him to hospital.

9. Officer 1 and Officer 2 reported their account of Ms C's behaviour to the Scottish Ambulance Service Emergency Medical Dispatch Centre and their comments were added to the incident record. Officer 1 and Officer 2 notified the alleged abuse to The Scottish Ambulance Centre Control Room Duty Manager (referred to in this report as Officer 3) and requested that Officer 3 advise the Police. Thereafter, the matter was considered and the decision to charge Ms C was made by the investigating Police Officers.

(a) Conclusions

10. I do not uphold this part of Ms C's complaint as there were no independent witnesses to verify Ms C's account of the events on 29 January 2004. There is no evidence to support Ms C's view that the behaviour of Officer 1 or Officer 2 towards her late father was inadequate and contributed to the worsening of her late father's medical condition.

11. There are no independent witnesses to support Ms C when she told me that she did not use abusive language towards Officer 1 and Officer 2 and, therefore, I do not uphold this aspect of Ms C's complaint.

12. The Scottish Ambulance Service said that there were no independent witnesses, as Ms C refused to allow the investigating team to interview either Mr or Mrs D. I agree that without independent witnesses, it remains impossible to verify the exchanges that took place between Officer 1, Officer 2 and Ms C on 29 January 2004. However, I find it unreasonable for the Scottish Ambulance Service to attribute the lack of independent witnesses to Ms C. In any event it is not clear if they would have been accepted as independent witnesses. Further, both her parents were elderly and Mr D was also critically ill and subsequently died within four months.

(b) The Scottish Ambulance Service failed to adequately deal with Ms C's subsequent complaint about Officer 1 and Officer 2.

13. Ms C telephoned the Scottish Ambulance Service on 30 January 2004 to complain about the behaviour of Officer 1 and Officer 2. The Scottish Ambulance Service complaint investigation was confirmed by letter to Ms C dated 2 February 2004 and Ms C received a final response dated 25 March 2004 from the Scottish Ambulance Service Corporate Affairs Manager (Officer 4) acting for the Chief Executive, rejecting the complaint. Ms C was not satisfied with this reply and telephoned the Scottish Ambulance Service on 23 April 2004 to discuss her dissatisfaction. Thereafter an agreement was reached that the Scottish Ambulance Service would forward Ms C's complaint for an independent investigation and review by a Divisional General Manager and Independent Reviewer (Officer 5).

14. As part of the independent investigation and review, a meeting took place

between Officer 5 and Ms C at her home on 18 May 2004. On 25 June 2004 Officer 5 telephoned Ms C who told him that her father, Mr D, had died on 1 June 2004. Officer 5 then wrote to Ms C on 25 June 2004 stating that he would contact Ms C 'in a couple of weeks' to arrange a further visit to her home to update her about her complaint. Officer 5 compiled a report dated 25 June 2004 about his Independent Review, which concluded that the Scottish Ambulance Service's original investigation had been carried out thoroughly and the outcome was correct. Officer 5 did not contact Ms C again or advise her about the results of his Independent Review.

15. As Ms C had not received any contact from Officer 5, she instructed a lawyer (L1) to enquire from Officer 5 about the result of her complaint and her meeting with Officer 5 on 18 May 2004. L1 wrote to Officer 5 on 9 September 2004. A reply was received from Officer 5 dated 17 September 2004, stating that Officer 4 was responsible for responding to Ms C and he had forwarded the enquiry letter from L1 to Officer 4 for his attention.

16. No reply from Officer 4 was received and L1 wrote to Officer 4 on 28 September 2004 and received a reply from him dated 12 October 2004. In his response, Officer 4 enclosed a copy letter from Officer 5 dated 2 September 2004, stating that the Scottish Ambulance Service were unable to uphold Ms C's complaint.

(b) Conclusions

17. On 25 June 2005 Officer 5 said (and confirmed in writing) that he would meet with Ms C 'in a couple of weeks' time. If this plan changed, he should have informed Ms C of the change. From 25 June 2004 up to receiving Officer 4's letter dated 12 October 2004 (following L1's enquiries), Ms C received no contact from the Scottish Ambulance Service about her complaint: that was maladministration. The Scottish Ambulance Service's independent investigation informed me that the reason was that no new information was likely to be revealed. However, this should have been timeously conveyed to Ms C. That is not an acceptable reason why Officer 5 did not contact Ms C as he told her he would, given the circumstances connected to Ms C's complaint.

18. For these reasons I uphold this part of Ms C's complaint.

(b) Recommendations

19. The Ombudsman recommends that the Scottish Ambulance Service:

(i) apologise to Ms C for their maladministration in the handling of her complaint;

(ii) review how they communicate the outcome of a complaint.

Summary

Specific complaints and conclusions

(a) The behaviour and attitude of Officer 1 and Officer 2 towards Ms C fell short of the standards expected *(not upheld)*

(b) The Scottish Ambulance Service failed to adequately deal with Ms C's subsequent complaint about Officer 1 and Officer 2 *(upheld)*

Redress and recommendations

The Ombudsman recommends that the Scottish Ambulance Service:

(i) apologise to Ms C for their maladministration in the handling of her complaint;

(ii) review how they communicate the outcome of a complaint.

21. The Scottish Ambulance Service has accepted the recommendations to review how they communicate the outcome of a complaint and I am pleased to note that they will issue a reminder to General Managers (and other staff investigating complaints) that they must keep any commitments to get back to complainants.

22. I am also pleased to note that the Scottish Ambulance Service will formally apologise to Ms C for the way her complaint was handled.

25 July 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs D	The complainant's mother
Mr D	The complainant's late father
Officer 1	Scottish Ambulance Service crew
Officer 2	Scottish Ambulance Service crew
Officer 3	SAS Control Room Duty Manager
Officer 4	SAS Corporate Affairs Manager
Officer 5	SAS General Manager & Independent Reviewer
L1	The complainant's lawyer