Scottish Parliament Region: Lothian

Case 200502396: Scottish Ambulance Service

Summary of Investigation

Category

Health: Ambulance; Delay

Overview

The complaint concerned the response time taken for an Ambulance to attend following an emergency telephone call. The complainant (Miss C) was unhappy about the delay and the explanations given for this.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was an inadequate response to a '999' call *(partially upheld);* and

(b) there was excessive delay in responding to Miss C's complaint and in the review which followed *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Service:

(i) provide the Crew involved in the incident with a copy of this report and ensure that steps are taken to identify and provide any training needs relating to responding to emergency calls;

(ii) apologise to Miss C and her family for the delays experienced while pursuing her complaint; and

(iii) review their complaint handling systems and procedure and, in particular, systems designed to track and monitor the progress of complaints.[1]

The Service have accepted the recommendations and will act on them accordingly.

[1] Prior to the laying of this report the Ambulance Service completed such a review and provided the Ombudsman with details of software they had installed which allowed the progress of complaints to be monitored centrally.

Main Investigation Report

Introduction

1. On 19 December 2005, the Ombudsman received a complaint from a woman (referred to in this report as Miss C) against the Scottish Ambulance Service (the Service). Miss C complained that when her late sister (referred to in this report as Mrs A) had collapsed at home on 2 June 2004 it had taken an ambulance 14 minutes to arrive following an emergency telephone call. She had complained to the Service about this on 8 July 2004. She received a letter detailing the results of their initial investigation on 11 October 2004. Miss C asked for this to be reviewed on 1 November 2004 and she received a further response on 10 January 2005. There was additional correspondence as Miss C sought more clarification and when Miss C complained to the Ombudsman she said that she remained unclear why the Ambulance had taken so long to respond on 2 June 2004 and was also unhappy with the length of time it had taken to respond to her concerns.

2. The complaints from Miss C which I have investigated are:

(a) there was an inadequate response to a 999 call; and

(b) there was excessive delay in responding to Miss C's complaint and in the review which followed.

Investigation

3. In investigating Miss C's complaint, I have read the correspondence between Miss C and the Service, reviewed the Service's internal complaint file including a report tracking the Ambulance's response, the note of the original incident, internal emails and memos, and interviewed the General Manager who had reviewed the Service's initial investigation (Officer 1).

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

(a) There was an inadequate response to a 999 call

5. The initial investigation was not carried out until October 2004. Miss C remained dissatisfied and an independent review[2] was held. Following this, it was accepted that it took 14 minutes for the ambulance crew (the Crew) to arrive at Mrs A's home and that they did so at 23.30 on 2 June 2004. The Service has a target of responding to 75% of Category A (life-threatening) calls within eight minutes by 2008. The review of the investigation undertaken by the Service revealed that, contrary to good practice, the Crew spent four minutes on a 'station security check' prior to leaving the station.[3] It also showed that the distance to Mrs A's home was only 4.5 miles and that the Crew had taken 9 minutes to drive this route. The Service has accessed a report based on satellite data which showed the Crew's response speed and have said that this was not 'indicative of the efficient response required for this emergency call.' In my discussions with the Service, they said that the speed limit for most of the route, which included a section of dual carriageway was 40 mph. The report logged the Crew's speed approximately every 13 seconds, the top speed recorded was 39 mph. The same report showed that the Crew stopped for one minute outside the station when another ambulance approached. In the letter of 10 January 2005 the Chief Executive stated:

'Frankly, [Miss C], I have little excuse for this less than satisfactory response and, as a result of this independent review I have arranged for immediate action to be taken to prevent any reoccurrence of such an unacceptable provision of this service.'

6. The letter stated these actions would include a review and change of procedures associated with Station security checks, a 'strong reminder' to the Crew of the need for a more efficient response in relation to speed en route and an investigation as to why the problems with the response were not identified in the initial investigation but in the review of that investigation.

7. In closing he added:

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[2] The complaints procedure of the Service has a second stage where the complaint can be reviewed by a Senior Manager from another division in the Service than that originally complained about. This is the independent review referred to here.

[3] This requires the last crew on station to check doors/windows are closed/locked, that the drugs cupboard is secured and that electrical appliances are switched off.

'The independent review of this complaint has clearly identified that there was a less than efficient response to this emergency call and, as a result, I have no hesitation in offering sincere and genuine apologies for this less than satisfactory provision of service.

8. I regret very much the obvious concern and anxiety caused on this occasion and would assure you that action will be taken to prevent a reoccurrence of this unacceptable situation.

9. Finally, [Officer 1] has expressed his gratitude to you and your family for your demeanour, courtesy and understanding when he met with you recently as part of the independent review of this complaint.'

10. Miss C sought further clarification and the Chief Executive explained what happens during a station security check but said that this should not be undertaken prior to attending a '999' call. He also provided Miss C with a copy of the report which showed the time and speed of the ambulance throughout the journey, explained sign-in procedures and, in response to her concerns as to whether the Crew were involved in any kind of industrial action ie 'work to rule', said there had been no 'work to rule'.

11. In response to my queries, I have seen a series of internal memos about this incident which began on the date that the letter of apology was sent to Miss C (paragraphs 5-7). In these Officer 1 confirmed that a station security check should not be followed prior to responding to an emergency call and procedure had not been correctly followed.[4] He also said the Divisional General Manager had been advised of the actions required to reinstate correct policy and that he had also discussed changes which had been made to operating procedures with the Senior Officer who had undertaken the initial investigation (Officer 2). The final memo dated 11 April 2005 detailed discussions which had taken place with Officer 2 who had agreed to investigate the Crew's track record.

[4] I have also had sight of the Service's good mobilisation practice guide which stresses all Crew should deploy immediately.

12. I interviewed Officer 1 twice in connection with this complaint and he confirmed that he had personally spoken to the Crew about their response time. He also provided me with copies of the reports produced by Officer 2 detailing the Crew's response times for February, March and April 2005 following the memo of 11 April 2005 (paragraph 9). Letters dated 18 May 2005 were sent to the two crew members which confirmed that Crew's should respond immediately to emergency calls and they should do so 'irrespective of the consequences of station security'.

13. I also discussed with Officer 1 the operating procedures put in place by Officer 2. He explained that all response times are logged and, 24 hours later, a printout of any response time which exceeded their standards (mobilise in 1 minute and attend within 8 minutes) is sent to Ambulance Station Managers. I understand that all such incidents are investigated retrospectively and where there are excessive mobilisation, appropriate action is taken.[5]

(a) Conclusion

14. In pursuing her complaint Miss C's main concern was to discover why the delay occurred. Unfortunately, in the absence of direct evidence, it has not been possible to confirm why an experienced Crew failed to respond appropriately to this emergency call. There does seem to have been some confusion about the policy surrounding station security but it is still not clear why their speed of response on route was on or below the speed limit.[6]

15. Following the review, which highlighted the significant failure that had occurred, actions were taken to prevent a recurrence. I have discussed the procedures put in place in detail and am satisfied that the Service is now proactively monitoring response times. However, in view of the identified serious failure by the Crew to respond adequately I consider action should also have been taken to identify any training needs arising from the incident. To this extent, I partially uphold this complaint.

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[5] Similar procedures apply throughout Scotland with slight variations to recognise local conditions.

[6] In the interview I had with him, Officer 1 noted that one Crew member had been unable to explain and the other had referred to busy traffic, roadworks and adverse weather. Miss C who also drove to Mrs A's home that night and arrived shortly after the Ambulance has said that this does not reflect her experience of the road conditions at the time.

(a) Recommendation

16. The Ombudsman recommends that the Service provide the Crew involved in the incident with a copy of this report and ensure that steps are taken to identify and provide any training needs relating to responding to emergency calls.

(b) There was excessive delay in responding to Miss C's complaint and in the review which followed

17. Miss C complained on 8 July 2004. She received an acknowledgement and completed a form to allow for the release of confidential information. On 27 September 2004 she received a letter saying that the Complaint Administrator was unavailable due to illness and there would be a delay. The response to her complaint was sent on 11 October 2004.

18. In response to my questions the Service have said that they were 'unable to provide any helpful explanation of the tardiness when responding to the initial complaint.' They also described the initial stages of their complaints handling procedure:

> 'what should happen is that local staff register the complaint on the Service's intranet. This triggers a complaint number which is unique to the complainant. A local file would be opened. The complaint would be passed to a manager to begin an investigation and an acknowledgement sent to the complainant. The details including copies of correspondence should then be sent to the National Complaints Administrator at the National Headquarters. … Once a complaint comes to the National Complaints Administrator it is entered into a database and follow ups will be made locally to ensure, where possible, that the complaint is dealt with within the prescribed timescales.'

19. From the internal email and case registration documents I have seen it appears that Miss C's complaint details did not correctly arrive at National Headquarters (HQ) until 24 August 2004 and only did so following a telephone call from Miss C about her complaint and subsequent follow up to this internally. Email correspondence dated 11 July 2004 indicates that an officer (Officer 3) completed a case evaluation report and contacted HQ to say that the complaint would be faxed on the following Monday. It is not clear whether this arrived or not or why an investigation was not triggered at this stage.

20. Once HQ were aware that this was not being investigated, a senior manager was appointed to do so (Officer 2) and an investigation report was signed on 24 September 2004. It was received at HQ on 5 October 2004. Unfortunately, as the Service later accepted, this was not a thorough investigation and did not reveal any of the problems which they subsequently discovered and that are referred to in paragraphs 5 to 7. In particular, despite Officer 2's seniority, he was not aware he could access the satellite data. He also did not drive the route and merely accepted the distance was 7.2 miles.[7]

21. On 1 November 2004 Miss C asked for a review of her complaint. She received the results of this in a letter of 10 January 2005. Letters updating her on the progress of this review were sent to the wrong address.

22. Miss C asked for additional clarification in a letter of 18 January 2005. The answers to these questions were sent by Officer 1 to headquarters on 30 March 2005 with an apology for the delay caused by difficulties in arranging meetings. Miss C received this additional information on 12 May 2005.

23. In response to the criticism in the review by Officer 1 of the initial investigation, the Chief Executive initiated a further internal investigation and the memo to him 11 April 2005 (see paragraph 9) dealt with this in detail. The memo states that Officer 2 had said he had been concerned about the delay and that this had led to the investigation not being as thorough as it should have been. It is also reported that, in the conversation with Officer 2, it had been stressed to him that complaint handling should always be 'based on the analysis of solid evidence' and that Officer 2 had expressed his regret and offered to apologise to the family. In light of the fact that Officer 2 had been unaware of the importance of the satellite report, a letter would be sent to all staff at the same level setting out 'what questions we expect to be asked of whom'.

(b) Conclusion

24. Although the Service have sought to prevent the inadequacies of the original investigation being repeated, there were a number of points when the Service failed to respond to Miss C's complaint or to keep her informed of progress. The

[7] See paragraph 5 where the correct distance is accepted as 4.5 miles.

initial complaint by Miss C was not logged correctly according to the Service's own procedure and they have been unable to explain why this was so. Although the review was carried out within a reasonable time scale and was extremely thorough, an error in the address held for Miss C meant she was not informed of progress. No attempt was made to keep her informed of progress in replying to her additional concerns and, although the Service did apologise for the delay in responding to her further concerns, it is not clear why they did not do so before 12 May 2005 following the response from Officer 1 on 31 March 2005. On the basis of the evidence, I, therefore, uphold this complaint.

(b) Recommendation

25. The Ombudsman recommends that the Service:

(i) apologise to Miss C and her family for the delays experienced while pursuing her complaint; and

(ii) review their complaint handling systems and procedure and, in particular, systems designed to track and monitor the progress of complaints and remind staff of the need to follow these procedures.[8]

26. The Service have accepted the recommendations and will act on them accordingly.

30 January 2007

[8] Prior to the laying of this report the Ambulance Service completed such a review and provided the Ombudsman with details of software they had installed which allowed the progress of complaints to be monitored centrally.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
The Service	Scottish Ambulance Service
Mrs A	The complainant's late sister
Officer 1	The General Manager in the Service who undertook the review of the initial investigation
The Crew	The ambulance crew who responded to the emergency call
Officer 2	The Senior Manager in the Service who undertook the initial investigation
HQ	The Services' National Headquarters
Officer 3	A member of the Service's staff who handled the initial complaint