**Scottish Parliament Region: Glasgow, Lothian and North East Scotland**

**Cases 200502049, 200502361, 200502362: NHS 24, Scottish Ambulance Service and Tayside NHS Board**

**Summary of Investigation**

***Category***

Health: NHS 24, Out-of-hours GP Services, Ambulance Services

***Overview***

The complainant (Mr C) raised a number of concerns regarding the delay in diagnosing his sister's stroke and admitting her to hospital.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) NHS 24 failed to make a correct diagnosis despite evidence to indicate that Mrs D had suffered a stroke (*not upheld*);
(b) NHS 24 failed to give this case a high priority (*not upheld*);
(c) NHS 24 incorrectly called for an out-of-hours GP rather than an ambulance (*not upheld*);
(d) the GP failed to stay with the patient whilst waiting for the ambulance (*upheld*);
(e) the GP failed to give the case a high priority (*upheld*);
(f) the GP failed to provide a referral note to the hospital (*not upheld*); and
(g) the ambulance took an unreasonable time to attend (*upheld*).

***Redress and recommendations***

The Ombudsman recommends that the Board:

(i) reflect on what lessons can be learned from this case;
(ii) consider how to communicate these lessons to Practitioners; and
(iii) advise her of their conclusions.

The Ombudsman recommends that the Service:

(iv) issue a further apology to Mr C and his nephew Mr D in respect of the additional delays in responding to the call from the GP;
(v) issue an apology for the incorrect information detailed in their earlier response to the complaint; and
(vi) consider reviewing their procedures for adhering to timescales for

attendance at incidents, particularly with a view to ensuring that the correct information is provided to callers.

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

## Main Investigation Report

### Introduction

1. On 27 October 2005 the Scottish Public Services Ombudsman Office received a complaint from a member of the public (Mr C) concerning the care provided to his sister (Mrs D) between the time she suffered a stroke and when she was admitted to hospital. The complaint concerns three separate organisations, NHS 24 with whom contact was initially made, Tayside NHS Board (the Board) who operated the out-of-hours GP service and the Scottish Ambulance Service (the Service).

2. Mrs D telephoned her son Mr D at his home on 21 March 2005 to say that she felt very unwell and needed his help. Mr D immediately telephoned NHS 24 at 20:58 to request assistance. NHS 24 asked for his mother's contact details and advised that they would contact his mother to obtain details of her condition. The NHS 24 operative then called Mrs D but her telephone was engaged as she had not replaced the receiver after the previous call to her son.

3. NHS 24 called Mr D back at 21:02 and took some of his mother's details. Mr D told them that he would go immediately to her house. He was advised that on arrival he could call an ambulance or call NHS 24 and speak to a Nursing Adviser.

4. Mrs D had a history of a stroke with a right sided weakness in the past as well as a heart valve replacement in 1992. She was on warfarin, a treatment to reduce the chance of a blood clot developing on the heart valve.

5. When Mr D reached his mother's house he found her lying on the floor. He called NHS 24 at 21:38 and advised them that he thought that his mother had had a stroke and that they had better send for an ambulance. The NHS 24 nurse asked Mr D a number of questions about his mother's condition and very briefly spoke to Mrs D. The NHS 24 nurse advised Mr D that as his mother was conscious and not confused, she did not need an emergency ambulance. She advised that she would request that an out-of-hours GP attend within an hour.

6. When the out-of-hours GP (the GP) attended at 22:26 he advised Mr D that his mother had suffered a severe stroke and needed hospitalisation. He called for an ambulance at 22:37 and explained the prognosis to Mr D. As he felt he could do no more for Mrs D at that stage, the GP left.

7. The ambulance arrived almost two hours later at 00:26. On the way to Perth Royal Infirmary, Mrs D's condition deteriorated and the ambulance was diverted to the Accident and Emergency Department where it arrived at 01:00. Mrs D's death was certified at 03:20.

8. When examining the complaint the Service admitted that the ambulance was delayed and did not meet the schedule agreed.

9. Mrs D's family were not happy with the diagnosis of Mrs D's condition and the delay of over 4 hours between first contact with NHS 24 and admission to hospital, only 6 miles from Mrs D's home. As a result of this they raised formal complaints with NHS 24, the Board who operated the out-of-hours GP service and the Service. Mr C was not satisfied with the responses he received to his complaint and as a result, requested that the Ombudsman's Office investigate his concerns.

10. The complaints from Mr C which I have investigated are that:

(a) NHS 24 failed to make a correct diagnosis despite evidence to indicate that Mrs D had suffered a stroke;
(b) NHS 24 failed to give this case a high priority;
(c) NHS 24 incorrectly called for an out-of-hours GP rather than an ambulance;
(d) the GP failed to stay with the patient whilst waiting for the ambulance;
(e) the GP failed to give the case a high priority;
(f) the GP failed to provide a referral note to the hospital; and
(g) the ambulance took an unreasonable time to attend.

**Investigation**

11. I have examined correspondence including responses to Mr C's complaints from all parties. I have made written enquiries of NHS 24, the Board and the Service and have obtained the records of events from these organisations including a copy of the recorded telephone calls between NHS 24 and Mr D. I have also sought clinical and specialist advice from our Independent Professional Advisers. I have set out, for each of the headings of Mr C's complaint, my findings of fact and conclusions.

12. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C, NHS 24, the Board and the Service were given an opportunity to comment on a draft of this report.

**(a) NHS 24 failed to make a correct diagnosis despite evidence to indicate that Mrs D had suffered a stroke; (b) NHS 24 failed to give this case a high priority; and (c) NHS 24 incorrectly called for an out-of-hours GP rather than an ambulance**

13. Mr C has raised concerns that despite Mr D clearly explaining concerns regarding the seriousness of Mrs D's condition and indeed pointing out to NHS 24 staff that he believed that she had had a stroke, they failed to diagnose a stroke.

14. Mr C believes that given the clear urgency highlighted by Mr D in his telephone calls with NHS 24 and given Mrs D's medical history (she had suffered a stoke in the past) and the symptoms described, NHS 24 should have called an emergency ambulance rather than the out-of-hours GP service.

15. In NHS 24's response to Mr C, the Nurse Director has advised that:

> 'Whilst some presenting symptoms can enable the Nurse Adviser to make a differential diagnosis, the fundamental role of the Nurse Adviser in NHS 24 is to assess and identify each patient's clinical needs and to decide who is the right person to treat the symptoms, when the treatment is required and where this will be met.'

16. Once the assessment had been completed, the Nurse Adviser gave the opinion that, based on the response provided by Mr D and Mrs D, Mrs D did not at that stage require an emergency ambulance. The Nurse Adviser believed based on the information she had obtained in the assessment, that Mrs D required a visit by an out-of-hours GP. She explained to Mr D that, because his mother was alert and orientated and breathing normally, an emergency ambulance did not appear at that stage to be warranted. The Nurse Adviser did mention that if the situation worsened in any way and if Mrs D suffered from a reduced level of consciousness or if she failed to respond to Mr D, he should call for an ambulance.

17. NHS 24 then arranged for the GP to visit through the out-of-hours GP service provided by the Board.

*Independent Professional Adviser*

18. I have sought advice from an Independent Professional Adviser (Adviser 1) who has considered the clinical background to the case and the actions taken by the NHS 24 Nursing Adviser in her handling of the assessment.

19. Both Adviser 1 and I have reviewed the background documentation and listened to the recordings of the telephone conversations between the Nursing Adviser and Mr D.

20. Adviser 1 has detailed that he considers that the symptoms Mr D described to the NHS 24 Nurse Adviser were of bilateral chest pain and general weakness which are not typical of a stroke. Further questioning established that Mrs D had power in her limbs although her fingers were cold. The NHS 24 Nurse Adviser repeated the question concerning Mrs D's power in her limbs and it appeared from the response that, at that time, Mrs D did not have weakness in her limbs which if present could indicate that she may have had a stoke.

*(a) Conclusion*

21. The background to this aspect of the complaint has been examined thoroughly by both myself and by Adviser 1. By reviewing the recorded telephone calls between Mr D and the NHS 24 Nurse Adviser, Adviser 1 was able to consider whether the actions taken by the Nurse Adviser were appropriate and in particular whether, based on the information available to her, she made the correct differential diagnosis.

22. From the review of the available evidence, and in particular the recording of the telephone conversations between Mr D and the NHS 24 Nurse Adviser, we are of the view that the actions taken by the NHS 24 Nurse Adviser were appropriate under the circumstances.

23. Although Mr D was concerned at the time that his mother had suffered a stroke, the symptoms described to the Nurse Adviser did not indicate that was the case. In light of our review of the evidence, we agree with this assessment and do not uphold this aspect of the complaint.

*(a) Recommendation*

24. The Ombudsman makes no recommendations on this point.

*(b) Conclusion*

25. Based on our review of the evidence, both myself and Adviser 1 consider that the NHS 24 Nurse Adviser's request for an out-of-hours GP to attend within an hour was an appropriate action to take given the evidence available. As a result of this, I do not uphold this aspect of the complaint.

*(b) Recommendation*

26. The Ombudsman makes no recommendations on this point.

*(c) Conclusion*

27. As has been previously mentioned, the symptoms described by Mrs D did not suggest that she had suffered a stroke. As she was conscious and aware of what was happening, the decision was made that an out-of-hours GP referral would be appropriate. This was requested within one hour. Adviser 1 has confirmed that based on the information available, the correct decision was made to request an urgent GP referral. As a result, I do not uphold this aspect of the complaint.

*(c) Recommendation*

28. The Ombudsman makes no recommendation on this point.

**(d) The GP failed to stay with the patient whilst waiting for the ambulance; (e) The GP failed to give the case a high priority; and (f) The GP failed to provide a referral note to the hospital**

29. Mr C was concerned that once the GP had examined Mrs D and requested an ambulance, he did not stay with Mrs D and her son despite what was, by that stage, a very serious diagnosis.

30. A response to this aspect of the complaint was provided by the Board as they were responsible for the out-of-hours GP service. The response to Mr C's complaint from the Board was provided by the Head of Service of the Board's Primary Care Division.

31. In his response, the Head of Service advised that the GP who attended Mrs D, arrived at Mrs D's home at 22:26. On arrival he performed an examination and recorded Mrs D's history. During the course of the examination it became clear to the GP that Mrs D's condition was poor. His examination indicated that she had suffered a dense cerebro vascular accident (severe stroke). As a result of this diagnosis it was clear to the GP that he

could not provide the treatment required by Mrs D and that she needed admission to hospital.

32. The Head of Service has advised that the GP discussed his findings with Mr D including the diagnosis and poor prognosis, he also sought Mr D's consent to transfer Mrs D to Perth Royal Infirmary. The GP then contacted the Service and requested a transfer to hospital within a one hour timeframe.

33. The GP then stated that he recapped the situation to Mr D to ensure he had no queries and as Mrs D did not seem to be suffering and as the GP felt there was nothing more he could do for her, he left pending arrival of the ambulance and arranged for the letter of referral to be faxed to the hospital.

34. Adviser 1 is of the view that it is very difficult to clearly assess what the situation was at the time, based on the limited information available. However, he considers that the GP perhaps did not fully appreciate the extent of what was a fairly rapid deterioration in Mrs D's condition prior to his visit. He considers that the GP could have established this by the lack of neurological symptoms when the initial assessment was made by NHS 24 and severe neurological symptoms at his visit. Adviser 1 considers that had the GP been fully aware of the sudden and severe change in condition, the GP would not have been likely to be happy to leave Mrs D for what it was assumed at the time could be for at least an hour.

35. Mr C complained that the GP did not leave a referral letter for the ambulance crew who arrived to take Mrs D to hospital. He advised that the crew appeared to expect to receive such a letter.

36. This point has not been reviewed by the Board as Mr C has not raised it directly with them. I have, however, reviewed the records and can confirm that a contact sheet with details of the GP's examination is held on file.

*(d) Conclusion*

37. It is clearly easier to give an opinion in hindsight. However, Adviser 1 has suggested that, on balance, the GP should have recognised the severe and rapid deterioration in Mrs D's condition and stayed with her until the ambulance arrived. As it would not be reasonable to suggest that the GP stayed for an hour or more for the ambulance, an urgent ambulance should have been called. As the GP did not wait on this occasion, I uphold this aspect of the complaint.

*(e) Conclusion*

38. As mentioned in (d) above, Adviser 1 is of the opinion that an urgent ambulance should have been requested. As a result, I uphold this aspect of the complaint. I must add, however, that this decision is made in hindsight and that the degree of weight given to this aspect of the complaint must be tempered by the difficulty in making a clear judgment on the basis of the information available and the situation at the time for the GP.

*(d) and (e) Recommendation*

39. The Ombudsman recommends that the Board reflect on what lessons can be learned from this case and consider how to communicate these lessons to Practitioners. She also requests that they advise her of their conclusions.

*(f) Conclusion*

40. It is a frequent practice for GP's to fax referral forms to hospital such as happened in this case. I do not believe that the GP's failure to provide a referral notice to the paramedics had any effect on the care provided to Mrs D. I do not uphold this aspect of the complaint.

*(f) Recommendation*

41. The Ombudsman has no recommendation to make on this point.

**(g) The ambulance took an unreasonable time to attend**

42. Mr C has complained that the Service took an unreasonable length of time to take Mrs D to hospital. He believes that the GP called for an ambulance at around 22:15. Some time afterwards, Mr D's partner who was at his home received a telephone call from NHS 24 advising that the ambulance would be delayed. Mr D subsequently called NHS 24 a number of times to try and hurry the ambulance, during these calls he spoke to at least three different people and at one stage was asked for the location of the village where his mother lived. He goes on to advise that the ambulance arrived at 00:30 on Tuesday 22 March and transferred Mrs D to hospital by around 00:45.

43. In response to Mr C's complaint, the Corporate Affairs Manager of the Service wrote to Mr C in an attempt to address his concerns. In his letter, the Corporate Affairs Manager advised that the Service received a telephone call from the Tayside out-of-hours GP service at 22:37 on 21 March. He further stated that GP requests are handled within a timescale and in this case, it was

agreed that the ambulance would attend within one and a half hours.

44. The Service has a procedure for use when an ambulance is not able to respond to a request within the agreed timescale. In this case, the Emergency Medical Dispatch Centre contacted the Tayside out-of-hours GP service at 23:51 to advise of the delay. The out-of-hours GP service advised that they would update Mr D of the situation.

45. I have examined the information provided by the Service and sought advice from an Independent Professional Adviser (Adviser 2) who specialises in ambulance services.

46. The Service have stated that they had agreed with the out-of-hours GP service that the ambulance would arrive at 00:07. They have since stated that because of the high level of emergency demand at that time, the ambulance was only dispatched at 00:08 and did not reach Mrs D until 00:26 around half an hour late. They have admitted that they failed to respond within the agreed timescales and have apologised to Mr C for the delay.

47. In the letter of 5 September 2005 responding to Mr C's complaint, the Service advised that the request from the out-of-hours GP service was received by the Service at 22:37 on 21 March. The Service have stated in this letter that it was agreed that the ambulance should be with Mrs D by 00:07, an hour and a half after the initial call. However, having viewed the computer records of the call, it appears to me that the agreed attendance time was one hour from the time of the call. I believe that the Service had expected to attend by 23:37 and had given the time of 00:07 as that of the expected time of arrival at hospital. This would be in agreement with the GP's view. He had also considered that he had requested attendance within an hour.

48. The computer records of the calls and subsequent action by the Service detail the following:

21 MAR 22:37:52 At Patient Side By 23:37 By LAI (LAI is the data imputer)
21 MAR 22:37:54 Travel 30 Minutes By LAI On Pt7

49. From this information I am of the view that the original intention had been for the ambulance to attend within the hour. It appears that there was confusion over the scheduled attendance time with this being documented as being 00:07 despite the computer records indicating a time by bedside of 23:37.

50. This apparent confusion in respect of the agreed attendance times added to the delay already admitted by the Service of half an hour and led to the ambulance actually attending around an hour later that was expected by the GP and Mr D. During this time Mrs D's condition clearly deteriorated.

*(g) Conclusion*

51. The issue of delay in the ambulance arriving has been acknowledged by the Service, they have additionally offered an apology for this delay. However, they have considered that the delay was only half an hour. I believe that the delay was actually an hour.

52. From my review of the information available it appears that there was some degree of confusion on the part of the Service in respect of agreed timescales for attendance. I consider the evidence suggests that the agreed time of attendance was 23:37 and not 00:07 as indicated in the response to the complaint by the Service. As a result of this, I uphold this aspect of the complaint.

*(g) Recommendation*

53. The Ombudsman recommends that the Service issue a further apology to Mr C and his nephew Mr D in respect of the additional delays in responding to the call from the GP and the incorrect information detailed in their earlier response to the complaint. She also recommends that the Service consider procedures for adhering to timescales for attendance at incidents, particularly with a view to ensuring that the correct information is provided to callers.

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

18 July 2007

**Annex 1**

## Explanation of abbreviations used

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| Mr C | The complainant |
| Mr D | The complainants nephew and Mrs D's son |
| Mrs D | The complainants sister |
| The GP | The out-of-hours GP |
| The Service | Scottish Ambulance Service |
| The Board | Tayside NHS Board |