Scottish Parliament Region: Lothian and Highlands and Islands

Cases 200701012 & 200701348: Scottish Ambulance Service and Western Isles NHS Board

Summary of Investigation

Category

Health: NHS Boards; Other
Health: Ambulance; Policy/administration

Overview

The complainant (Mr C)'s brother (Mr A) collapsed suddenly on 1 January 2007 while at his mother's home in Uig, Isle of Lewis. Mr A was taken to hospital by ambulance. Mr C raised a number of concerns: that a GP working for Western Isles NHS Board (the Board) out-of-hours service did not attend, although the Scottish Ambulance Service (the Service) requested he do so; a First Responders Unit (FRU) was not correctly called; and information was released to the press, relating to this incident, inappropriately. The Service accepted the problem with the FRU but Mr C remained concerned about the actions taken to remedy this.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) a GP working for the Board unreasonably did not attend (*partially upheld, to the extent that there were clear issues with communication on the night of 1 January 2007*);
(b) a FRU was not correctly called and actions taken to remedy this were insufficient (*not upheld)*; and
(c) information was released to the press inappropriately (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) the Board review the equipment provided to out-of-hours GPs, in the light of the problems identified in this report;
(ii) the Board and the Service meet to consider how best to respond to the communication failures identified and ensure that lines of responsibility and procedures are clearly in place where appropriate;

(iii) the Service undertake a short review of emergency calls in FRU areas, to see if they can identify cases where FRUs could have been called but were not and consider if any lessons can be learned from this;

(iv) the Service apologise to Mr C for the release of inaccurate information; and

(v) the Board and the Service use this complaint as a case study with press staff, in order to encourage learning from the problems identified.

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

Main Investigation Report

Introduction

1. Mr A was staying at his mother's home in Uig on the Isle of Lewis on 1 January 2007 when he collapsed. An emergency call was made and an ambulance dispatched. A request was also made by the Scottish Ambulance Service (the Service) that a GP attend and the local NHS hub (the Hub) for the out-of-hours service was contacted. The GP at the out-of-hours hub in Stornoway initially indicated he would attend but contacted the Service later to ask if he was required. The ambulance crew (the Crew) were contacted while on route and, when they arrived in Uig, asked about the GP attendance. The GP said he had set out but got lost and then returned to the Hub, as he knew the ambulance would have reached Mr A by that time.

2. The ambulance took Mr A to the Western Isles Hospital, Stornoway. He was noted to be conscious on admission but, sadly, died two weeks later.

3. Mr A's brother, Mr C, complained to the Western Isles NHS Board (the Board) and the Service about the failure of the GP to attend and that the Service did not contact the local First Response Unit (FRU)[1]. He also said that information had been given to the press which was both inaccurate and which had not been given to the family first. In their response to Mr C's complaint, the Service confirmed that they had failed to contact the nearest FRU and that changes had been made to their system as a result. The Board, in their response to Mr C, said that GPs at the out-of-hours hub were employed solely to answer non-emergency calls. The Service could contact a local doctor when responding to an emergency call but there was no obligation on him to attend. Mr C remained unhappy with the response and complained to the Ombudsman.

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

(a) a GP working for Western Isles NHS Board unreasonably did not attend;
(b) a First Responders Unit was not correctly called and actions taken to remedy this were insufficient; and
(c) information was released to the press inappropriately.

[1] Volunteers who offer first response in remote areas (see paragraph 24).

Investigation

5. In investigating this complaint I have obtained the background documentation relating to the complaint and Mr C's medical records from the Service and the Board. Enquiries have been made of the Board and the Service. Advice was also obtained from a clinical adviser to the Ombudsman (the Adviser).[2]

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

(a) A GP working for Western Isles NHS Board unreasonably did not attend

7. The Service provided tapes of the calls made on the evening of 1 January 2007, as well as their call out sheet. The initial telephone call was made at 18:31. At that stage Mr A, who was aged 46, was reported to be unconscious and not breathing. The Service asked for a GP to attend and contacted the out-of-hours service. The GP said he would attend and received detailed directions. During this call, it was clear that the GP did not know the area well.

8. At 19:04, the GP called the Service to ask if the Crew could contact him. The Despatch Centre for the Service (the Centre) were unable to contact the Crew because of difficulties with mobile telephone reception. The GP called again at 19:18, saying he had not noted the details and they had not appeared on the system (see paragraph 11). The Centre confirmed the patient's name and location. The GP was told he should attend and that this was a cardiac arrest.

9. The Crew pulled up on the road to call the Centre. It was not clear when this occurred as it did not appear to be logged but the call was recorded. A crew member asked if the GP was coming from Stornoway. The crew member said she knew the GP, who was a locum, and he would not know the area.[3]

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[2] The standard used in this report for assessing the actions of medical staff is whether the actions were reasonable. By reasonable, I mean the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

[3] In their response to a draft of this report, the Board confirmed that the GP was not a locum but had been employed by one of the local practices between April 2006 until September 2007

She was told the patient was unconscious and she confirmed there was a paramedic on board. There were concerns that this was a sudden death. The GP called the Centre again at 19:31. He said he had been on a house call and that two more house calls were on the system. He asked if he was needed. He was told he was and advised to attend. The Crew called the Centre at 19:44. They said the patient was breathing but unconscious. They asked if the GP was on his way but decided, as it was likely he had left Stornoway only 20 minutes previously, that they should proceed.

10. In the response to the original complaint, the Board said to Mr C that the GP was only employed to deal with non-emergency out-of-hours cases; the Service had paramedic staff who could deal with emergencies. However, where it was known a local GP was available they would advise the Service of this. No GP was under an obligation to attend if a request was made[4]. The out-of-hours room included detailed maps with sketches of the villages showing individual houses but the GP got lost in the dark and his assessment was that the ambulance would have arrived by then and he, therefore, returned to Stornoway.

11. In the course of my investigation, the GP provided a statement[5]. He said he had been on a shift from 08:00, which was scheduled to finish at 20:00. He was aware he was the only GP covering the island and, at the time of the call, there were patients waiting in the out-of-hours centre and he had house calls to make. He realised, following the 18:30 call, that he had not registered the details of how to find the location and had called for further information at 18:40. He was informed at 18:45 that he was still required to attend and said he 'felt he had little choice but to set off' and did so at about 19:00.[6] He said that because of the possibility of ice on the road he took an hour to reach Uig and then got lost. At this stage he returned to the Hub. He added:

> 'In hindsight I was of the view that the telephone call to me was inappropriate and unpractical as there was simply very little possibility of me being able to render assistance to a patient over 35 miles away, particularly as I had been informed that the Ambulance had been

[4] There was a local GP, based in Uig, who was not on duty or at home. However, it appears he was not contacted on the night.

[5] The original Board investigation relied on the out-of-hours note and the calls from the Service.

[6] This does not match the call times but I have noted the statement was given almost one year after the events and does match the pattern of calls.

dispatched to attend to the patient. Furthermore, with hindsight, I now realise my primary duty was in fact to the patients who had come to the Centre, and I should simply have informed the Ambulance Control that it was not appropriate, nor possible for me to attend.'

12. I asked the Service to comment on why the GP had been requested to attend and why, in general, they would request GP attendance. The Crew also provided a statement. It was said the original call was made because of the description of Mr A being in likely respiratory or cardiac arrest. The Crew said that in the past a GP who lived near Mr A's mother's home would attend if called, even if off duty, and this was why they had requested a GP. However, they were told that it was the GP from Stornoway who had been asked to attend.

13. The Service also provided some general comments. They said that if this had been confirmed as a fatal incident, the GP would have been required on the scene for certification. Also, medical support was of great value where life-threatening complications occur. However, they confirmed that ambulance crews were trained in dealing with such emergencies and the double crewed vehicle was staffed by a paramedic. The only other resource available on the island was an ambulance staffed with two technicians.

14. In their response to my queries, the Board said that it was 'normal practice' for GPs to use their own judgement when prioritising calls but many would call local ambulance staff to find out if they were required. The Board were aware that a neighbouring Board had stopped dual response (response by both a GP and an ambulance) and they had also reviewed this. In doing so, they had noted that in a number of cases a response by an ambulance and a GP had meant a hospital admission had been avoided and the patient able to remain at home. Given this, they had decided to retain the current system (see paragraph 3). Both the Board and the Service confirmed there were no policies in places covering requests for GP attendance by the Service.

15. In reviewing the evidence, the Adviser has said that it was unclear what medical need required a GP as well as an ambulance in this case and that thought had not been given to the available resources when contacting the GP. He noted that, while it was accepted the GP had no obligation to attend, it was difficult for him to say no, given the repeated requests which clearly stated attendance was expected.

16. The Adviser also felt that a number of important questions had been left unanswered by the response from the Board. In particular, he had commented on the GP getting lost and asked for information about the resources available. They had said this was not a locum but a local GP but this did not explain why they had not considered providing equipment such as satellite navigation generally or why they had not acted on the problems relating to mobile telephone coverage. It was further noted that, in the recent NHS Quality Improvement Scotland report on out-of-hours, the Board were criticised for their failure to put plans in place to support policy development and service delivery and that reporting on clinical governance issues relating to out-of-hours services was still on an ad hoc basis.[7]

17. In considering the resources available on the evening, the Adviser said that the response by ambulance was, ultimately, the appropriate one but that the confusion between the ambulance and the GP meant Mr C's family had been left feeling they had not received an appropriate response and also that this had meant considerable time had been spent by the GP and the Centre which, admittedly with hindsight, had not been needed.

(a) Conclusion

18. The difficulty of providing rural emergency cover has been previously acknowledged by the Ombudsman's office (see complaint numbers 200603457 and 200700450). The Adviser has said that, in the circumstances, sending the Crew was the appropriate response and GP attendance does not appear to have been required, from a clinical perspective. The Crew have said their initial request was based on the possibility of a GP based nearby. However, there is no evidence this GP was ever contacted[8] as the only call logged was to the out-of-hours GP. The request was not reviewed in light of this. Having listened to the calls, it is also clear that, at some point in their journey, the Crew were aware it would be unlikely the GP would or could attend because he had not yet left Stornoway. I am concerned that, despite this, the Centre repeated the request to attend and it remains unclear why. From listening to the recorded calls, I fully accept the Centre were under considerable pressure in a busy period and trying to achieve the best response for Mr A. However, it should

[7] This refers to the December 2007 follow-up report on the Provision of Safe and Effective Primary Medical Services Out-of-Hours.

[8] This GP later confirmed that he had not been at home.

have been clear that, given the location of the GP and the resources available, once the GP had begun to call back with concerns, there was little point repeating their request for attendance.

19. It does seem from the calls that there was some concern this was a sudden death incident and it appears that a GP was felt to be required as certification may have been needed and this may explain why the out-of-hours GP was requested. However, this was not clearly communicated to him and it was also not clearly communicated that he could say no. In the end, it appears the GP set off after the Crew had arrived at the location at a time when this would clearly have been of little use. He got lost and any other calls he was required to make were delayed.

20. The Board have said there have been benefits in allowing dual response and I do not wish to discourage flexibility but the communication on 1 January 2007 between the Service and the GP was neither clear nor effective. As should be clear from paragraphs 18 and 19, despite having listened carefully to the calls and read the statements, there remain questions about the sequence of events and the reasons behind the decision-making on the night. There are no polices in place to cover such requests and I have also noted that NHS Quality Improvement Scotland noted concerns about monitoring the out-of-hours service and have considered this in formulating the recommendations.

21. I am also concerned about the problems the GP had with finding the location and the problems that all staff had with the mobile telephone coverage. The Board have also said as a local GP he was using his own car. However, they did not appear to have given thought as to whether this was adequate, given the specific circumstances of the Western Isles, or whether appropriate technology should or could be provided as standard.

22. As the response that was provided to Mr A was appropriate, given the available resources, I have decided not to fully uphold this complaint. However, the lack of clarity about available equipment (see paragraph 19), issues with communication on the night (see paragraph 18) and the absence of any policies or procedures in place to either cover such requests or monitor the impact of them (see paragraphs 14 and 16) has led me to uphold this complaint in part. In the circumstances, the Ombudsman makes the following recommendations.

(a) Recommendation

23. The Ombudsman recommends that:

(i) the Board review the equipment provided to out-of-hours GPs, in the light of the problems identified in this report; and

(ii) the Board and the Service meet to consider how best to respond to the communication failures identified and ensure that lines of responsibility and procedures are clearly in place where appropriate.

(b) A FRU was not correctly called and actions taken to remedy this were insufficient

24. The Community FRUs are local community based schemes which equip local volunteers with specialist equipment and training to enable them to respond to emergencies before an ambulance arrives. Such schemes exist world wide because the period known as pre-hospital care is recognised as being of crucial importance and it has also been recognised that there are difficulties achieving this through ambulance response in rural and remote areas.

25. Some of the Scottish schemes are directly linked to the Service who may call upon them and some are even booked through the Service's central despatch system. On 1 January 2007, there was a relatively new scheme in operation in Uig. There was an FRU close to Mr C with equipment. The Service provided a copy of a call from the local FRU to them on 2 January 2007, showing the volunteer was clearly distressed at not having been called when he could have assisted. He also said this had happened before.

26. The Service have said the problems arose because the despatch system had logged the location for all FRUs as the Hub in Stornoway. In their response to Mr C, they accepted that was an error and said that new despatch points had been entered. They upheld the complaint on this basis and apologised to Mr A. In response to my enquiries, the Service provided details of guidance given to the FRU and the results of an initial review of the scheme logged the times the FRU had been called and included examples of incidents of interest. This included an incident where the Uig FRU had been called in July 2006 and was described as an excellent example of such a unit working closely with other services.

(b) Conclusion

27. Mr C and the volunteer in Uig were both upset and distressed that assistance which was available was not provided as a result of a failure in the way the Service had logged the location of volunteers. The Service have said they have changed the way FRUs are logged in their system. They have clearly accepted there was a failure and taken action to address this before this complaint was raised with the Ombudsman's office. However, I note that their review did not track incidents where an FRU could have been called but was not and why. I do not wish to increase the bureaucracy relating to this scheme but feel a short review of this may provide both the Service and volunteers with useful information and reassurance about the operation of the scheme. Therefore, while I am not upholding this complaint, the Ombudsman makes the following recommendation.

(b) Recommendation

28. The Ombudsman recommends that the Service undertake a short review of emergency calls in FRU areas, to see if they can identify cases where FRUs could have been called but were not and consider if any lessons can be learned from this.

(c) Information was released to the press inappropriately

29. In his complaint to the Ombudsman, Mr C was concerned about information that he had seen in the press about the incident. I asked both the Board and the Service for details of their policy and contact with the press. The press quoted direct from a named member of the Service and also referred to an official response from them. A local GP had also commented on his own behalf. The Board were also said to have made direct comment.

30. The Service said they did not issue a press release but that when they were contacted by a local paper they had said that the FRU had not been sent because a nurse was at the location. Following their own investigation, the Service have already acknowledged that this was not the case and explained the reason for the error in their response (see paragraph 26). In response to my enquiries, they explained their policy was to respond when details of a case were already in the public domain but not to release clinical information and that they had followed this policy in this case.

31. In response to my queries, the Board said they released no information to the press about this matter. However, a press article quoted the Board direct

and, from internal emails, it is clear that Board staff believed there had been contact. I have noted that the information referred to internally about the response matches the information published in the press.

(c) Conclusion

32. NHS Boards are often placed in a difficult position by press contact. The press were understandably interested in the case and the NHS do have a duty to respond when there is, for example, a need to reassure the public. I am satisfied that no clinical details were released. However, I consider there were problems with the press contact. The Service released inaccurate information based on a brief, initial investigation. They have already apologised to Mr C for the failure that they identified to contact the FRU (see paragraph 26) but not for the release of inaccurate information about this to the press (see paragraph 30) and the Ombudsman recommends that they do so now. The Board have said there was no release of information from them. However, the response attributed to them in the press matches internal email discussions about press contact. On the balance of probabilities, I find that there was contact and it appears that the Board had not tracked the contact in line with their draft policy. While a draft policy, this appears to have been in draft for some time. In all the circumstances, I uphold this complaint.

33. Mr A and his family were concerned that information in the press was not communicated to them first. While it is important to note no clinical information was released and it is clear the press were also in contact with the family, nevertheless, in the circumstances described above, I would have expected the Board and Service to have considered alerting the family to the fact that they had had press contact too. The Ombudsman recommends that both the Board and the Service use this complaint as a case study with their communications staff to ensure improvements are made in the future and I would ask them to also consider the family's concerns as part of this.

(c) Recommendations

34. The Ombudsman recommends that:

(i) the Service apologise to Mr C for the release of inaccurate information; and

(ii) the Board and the Service use this complaint as a case study with press staff, in order to encourage learning from the problems identified.

35. The Board and the Service have accepted the recommendations and will act on them accordingly. The Ombudsman asks that they notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	Mr C's brother
The Service	The Scottish Ambulance Service
The Hub	The local NHS Hub
The Crew	The ambulance crew
Mr C	The complainant
The Board	Western Isles NHS Board
FRU	First Responder Unit
The Adviser	The clinical adviser to the Ombudsman
The Centre	The despatch centre for the Service