Scottish Parliament Region: Lothian

Case 200802131: Scottish Ambulance Service

Summary of Investigation

Category

Health: Scottish Ambulance Service; delay

Overview

The complainant (Ms C) raised a complaint against the Scottish Ambulance Service (the Service) about the length of time it took for a paramedic response unit (the PRU) and accident and emergency vehicle to attend an emergency call-out when her brother, Mr A, collapsed with chest pains at her home. Mr A later died in hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the PRU took an unreasonable length of time to attend *(not upheld)*; and

(b) the accident and emergency vehicle took an unreasonable length of time to attend *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Service:	*Completion date*
(i) undertake the actions outlined at paragraph 19 of this report and provide him with evidence that these have taken place;	10 September 2010
(ii) review their current system for the allocation of back-up accident and emergency vehicles to PRUs, to ensure that the risk of unnecessary delay is minimised;	10 September 2010
(iii) consider introducing a system to record all calls from paramedics' mobile phones to the Emergency Medical Dispatch Centre; and	10 September 2010
(iv) apologise to Ms C for the failings identified in this report.	23 July 2010

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

Main Investigation Report

Introduction

1. The complainant (Ms C) raised a complaint against the Scottish Ambulance Service (the Service) regarding the time it took for a paramedic response unit (the PRU)[1] and accident and emergency vehicle to attend to an emergency call-out. Ms C's 46-year-old brother, Mr A, was visiting her home on 4 June 2008 and had collapsed with chest pains. Ms C telephoned 999 and requested a fast response. Ms C said that it took about 30 to 35 minutes for the PRU to arrive and one hour for the accident and emergency vehicle to arrive, following her initial 999 call. Mr A was transferred to hospital by accident and emergency vehicle but when Ms C and her family arrived a short time later, they were told that Mr A had died.

2. Ms C made a formal complaint to the Service regarding the delay in the attendance of the PRU and accident and emergency vehicle following her emergency call and received a response (through her Member of the Scottish Parliament) on 7 October 2008. Ms C was unhappy with the Service's response and she raised a complaint with the Ombudsman on 8 April 2009 seeking a full investigation into what had happened.

3. The complaints from Ms C which I have investigated are that:

(a) the PRU took an unreasonable length of time to attend; and

(b) the accident and emergency vehicle took an unreasonable length of time to attend.

Investigation

4. In investigating the complaint, my complaints reviewer has reviewed the correspondence and made written enquiries of the Service. My complaints reviewer also visited the relevant Emergency Medical Dispatch Centre (the EMDC)[2] and interviewed the EMDC manager (the Manager). My complaints reviewer also met with Ms C.

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[1] There are various different names the Service has used in the past for this type of unit including Fast Response Vehicle, Fast Response Unit and Rapid Response Unit. The current term is Paramedic Response Unit and this is the term that has been used in this report.

[2] All of the Service's operations are coordinated through three EMDCs. The EMDC receive 999 calls and dispatch responses, arrange some patient transport services to hospitals as requested by other medical professionals and manage air ambulance response.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Service were given an opportunity to comment on a draft of this report. Abbreviations are set out in Annex 1.

Ms C's account of events

6. On 4 June 2008, Mr A visited Ms C at her home. Mr A had a history of heart problems, including previous heart attacks. Ms C told my complaints reviewer that, while he was at her home, Mr A was sick and that Mr A had discussed with her that he had been feeling unwell recently. During the visit, Mr A began to experience severe chest pain and collapsed in the close outside her property. Ms C telephoned 999 at 12:55 and spoke with an operator at the Service (a member of EMDC staff). She then returned to Mr A to reassure him that help was on its way.

7. Mr A became uncomfortable again and Ms C called 999 again (although she cannot recall the exact time) and was told that help was on its way. Half an hour later, no help had arrived and Ms C called 999 and was again told that help was on its way. According to Ms C, the PRU paramedic arrived about 35 minutes after Ms C's first telephone call to the Service (about 13:30).

8. Ms C explained that, while the PRU paramedic was attending to Mr A, he became delirious and fell unconscious. The PRU paramedic called the EMDC on her own mobile phone to request urgent assistance at about 13:40 and began heart massage and shock treatment. The PRU paramedic passed her mobile phone to Ms C to contact the EMDC again to request urgent back-up. The shock treatment continued and at about 13:50 the paramedic gave her mobile phone to Ms C's friend (who was also present) to contact the EMDC to request that the accident and emergency vehicle bring oxygen. The accident and emergency vehicle arrived at 13:55.

The Service's records

9. All 999 calls to the EMDC are logged and recorded on their computer system. For each call-out there is a computer generated report which shows an audit trail of the call-out including: the time the initial call was received; the information provided by the caller about the problem; the resource lists generated for that call (a list of vehicles in the area of the emergency in order of distance); and status (with times) of any allocated vehicle. My complaints reviewer has received a copy of the computer generated report for this call-out

(the Call Report). The Service also keeps recordings of the calls made to them and my complaints reviewer has received copies of all the available call transcripts for this particular call-out. The Service do not record calls between paramedics' mobile phones and the EMDC.

10. The Call Report shows that the EMDC received Ms C's initial call at 12:55. The call transcript for this call shows that the EMDC staff member established the address of the emergency and the problem, and reassured Ms C that help was on its way. A list of the resources in the area of the emergency was generated at the EMDC at 12:58. The PRU was the closest available resource at the time and was 3.15 miles from the scene (an estimated seven minutes away). The Call Report records the PRU as being allocated to respond to the call at 12:59 and as arriving at the scene at 13:17.

11. A refreshed list of resources in the area of the emergency was not generated on the Call Report until 13:17. At 13:11, an accident and emergency vehicle with two paramedics had become available and, at 13:17, that vehicle was allocated to back up the PRU. It was 3.28 miles (an estimated seven minutes) away from the scene.

12. The Call Report shows that the PRU paramedic was in contact with the EMDC at 13:19 to advise that the patient was in cardiac arrest and this information was transmitted to the accident and emergency vehicle. The Call Report notes that a further call was received at 13:20 and the corresponding call transcript (which was made from the same telephone number from which the initial 999 call was made) indicated that a paramedic was in attendance at that time and was requesting oxygen suction. There is a note on the Call Report at 13:22 'ETA ENQ @ 13:22' and a corresponding transcript of this call (which was made from the same telephone number from which the initial 999 call was made). The Call Report records that the accident and emergency vehicle arrived at the scene at 13:24.

(a) The PRU took an unreasonable length of time to attend

13. The Call Report indicated that it took the PRU just over 18 minutes from the time it was allocated to respond to the call to travel 3.15 miles to the scene of the emergency (an approximate average speed of 10.5 miles per hour) (see paragraph 10).

14. Ms C's call was classed as an emergency call (Category A). The Service has a government target to respond to 75 percent of Category A calls within eight minutes of the call being received by the EMDC. The Manager explained to my complaints reviewer at interview that this target is for any response to a call, including a PRU. If the target is not met, the EMDC system requires that a reason be entered to explain the delay and this forms part of the Call Report. In this case, the out of performance reason given by the PRU paramedic was recorded on the Call Report as being due to 'excessive distance'.

15. Ms C formally complained to the Service about the delay in the PRU and accident and emergency vehicle attending (amongst other things). My complaints reviewer has had sight of the Service's internal investigation into the complaint. The investigation indicated that Ms C's complaint was upheld because, although the nearest available vehicle was sent (the PRU), it took 20 minutes to arrive on scene (see paragraph 10). However, the investigation did not establish why it appeared to take so long for the PRU to travel such a short distance. In the written response sent to Ms C, the Service did not refer to her complaint about the delay being upheld and explained that:

> 'The delay in responding to this call was due to very high demand on the Service at the time of the call. The nearest available resource at the time was the Fast Response Unit [the PRU] … All other resources were actively engaged in responding to other calls.'

16. The previous Ombudsman published a report (case reference 200502396) into a complaint about the delay in sending an accident and emergency vehicle to a call-out where there appeared to be an anomaly in the time taken for the responding vehicle to travel a relatively short distance. In that case, the Service had accessed a report based on satellite data which showed the vehicle's speed and location every 13 seconds en route to the scene. Based on that information, the Service had been able to conclude that the accident and emergency vehicle had not provided an efficient response to the call. In that case, a senior officer at the Service had undertaken a review of the initial complaint investigation and had highlighted concerns that the officer involved in the initial complaint investigation had not been aware that he could access the satellite data.

17. As part of my complaints reviewer's enquiries, the Service were asked to provide the satellite data report (the Satellite Report) for the PRU. There was no evidence from the Service's complaints file that the Satellite Report had been

considered as part of the investigation of Ms C's complaint. The Service explained to my complaints reviewer that their system only retains satellite data information for seven days after a call-out. After this, they have to request it from a third party, which can be expensive. However, in light of the circumstances of this case and the previous report (see paragraph 16), which my complaints reviewer brought to their attention, the Service agreed to provide her with the Satellite Report for the PRU.

18. The Satellite Report for the PRU showed that the vehicle was mobile (a speed was registered) by 13:00 and was stopped at the scene by 13:05. Therefore, although the Call Report indicated that it took the PRU 22 minutes from the initial call being received to attend at the scene, the Satellite Report showed that, in fact, it only took 10 minutes (call received at 12:55, PRU attended at 13:05). The Service explained that the difference in the times recorded on the Call Report and the Satellite Report was because the PRU paramedic did not press the 'on scene' button in her vehicle when she arrived, which would have accurately recorded the time of arrival on their system. However, when this happens, the EMDC system should automatically pick up and record on the Call Report the 'on scene' time when the vehicle is around 200 metres from the scene. Unfortunately, in this case, it would appear that there was a delay in this automatic recording being picked up by the system and the PRU was wrongly recorded as arriving at 13:17.

19. In light of the difference in times recorded, the Service undertook an audit of a random sample of calls on 3, 4 and 5 June 2008, which were all found to have recorded the 'on scene' time as correct. In response to the problem identified in this case, the Service have explained that this has led to the following action points being implemented:

- 'A memo to EMDC staff to advise that if a call is out of performance [see paragraph 14] they should ensure that the appropriate reason is selected.
- If it is apparent that an ambulance or Paramedic Response Unit has taken an abnormally long time to travel a short distance, the Service will review the satellite report where appropriate.
- Where a complaint is being investigated and there is reasonable doubt over the length of time taken for a vehicle to travel a short distance, requesting a satellite report will be considered.

- A bulletin to crews to reiterate the importance of pressing the 'on scene' button.'

(a) Conclusion

20. It is clear to me that Ms C recalls the PRU taking longer to attend than the Service's records show (the Call Report, the Satellite Report and the transcripts of the calls). In the absence of objective evidence to corroborate Ms C's account, I have decided to accept the Service's records as representing the accurate timings. I am satisfied that Ms C's call was received by the Service at 12:55 and the PRU arrived at the scene at 13:05. Despite the fact that the government target of eight minutes was not met, given that this target is for 75 percent of calls (therefore, taking account that not every call will be responded to within eight minutes) and the response was within 10 minutes, I do not consider that the PRU took an unreasonable length of time to attend. Therefore, I do not uphold this complaint.

21. However, it is of concern that the Service failed to identify the problem with the Call Report times prior to the complaint being raised with the Ombudsman's office by Ms C. It was clear at the time the 999 call was responded to that the PRU had apparently taken an inexplicably long time to cover a relatively short distance. While this investigation has established that this was not, in fact, correct, I am concerned that this was not followed up or investigated by the Service at that time. Also, the PRU paramedic was able to enter the out of performance reason 'excessive distance' without this being questioned or compared with the actual distance covered (3.15 miles).

22. When Ms C raised her complaint, the internal investigation concluded that, on the basis that it apparently took the PRU 20 minutes to respond to the call, the complaint was upheld (although this was not communicated to her). However, the reason for the apparent delay was not investigated and, in particular, the Service did not consider requesting a Satellite Report despite the anomaly between the time taken to cover the distance and the previous complaint investigation by the Service indicating that a Satellite Report should be requested in cases like this (see paragraph 16). As a result, the subsequent response to Ms C's complaint could not adequately explain why it took the PRU such a long time to cover such a short distance. I am concerned that the Service's complaints process was neither robust in its investigation of Ms C's complaint nor transparent in communicating the outcome to Ms C.

23. The Service has explained to me the steps that they are taking to prevent this problem being repeated and I am pleased that they are now taking these steps.

(a) Recommendation

	Completion date
24. Although I do not uphold this complaint, I recommend that the Service:	
(i) undertake the actions outlined at paragraph 19 of this report and provide me with evidence that these have taken place.	10 September 2010

(b) The accident and emergency vehicle took an unreasonable length of time to attend

25. The Manager explained to my complaints reviewer that, when a call is received, the EMDC will dispatch the closest available vehicle to the scene. In this case, the closest vehicle was the PRU. If a PRU is sent, the EMDC staff will then look for an available accident and emergency vehicle to back up the PRU. A PRU is intended to provide a fast response to an emergency call and is equipped with all of the life saving equipment needed in a medical emergency. However, unlike an accident and emergency vehicle, it does not have transportation facilities (so is unable to take patients to hospital) or some specialised equipment. The EMDC can select that no accident and emergency vehicle back-up is required, however, this is rare and the Manager confirmed to my complaints reviewer that there was no such selection in this call. Therefore, the PRU paramedic would have assumed that she was to be backed up by an accident and emergency vehicle.

26. The Manager explained to my complaints reviewer that there are no government targets or internal performance indicators which cover the time taken to back up PRUs. The Service's aim is to back up a PRU with an accident and emergency vehicle as soon as possible and that it is reasonable to assume a 14 to 20 minute response time. The Manager explained to my complaints reviewer that the Service monitor arrival times of back-up resources.

27. In response to Ms C's complaint about the delay in the accident and emergency vehicle attending, the Service explained that this was due to very high demand on the Service at the time of the call and that, apart from the PRU, all other resources were actively engaged in responding to other calls (see paragraph 15).

28. At the time the initial resource list was generated on the Call Report at 12:58 (see paragraph 10), the nearest available resource was allocated, the PRU. The Manager explained to my complaints reviewer that a PRU has to be backed up by an accident and emergency vehicle with at least one paramedic on board[3]. At the time of the initial call, the Call Report shows that there were no suitable and available vehicles on the resource list (which displays ten vehicles in order of distance from the scene) which could back up the PRU. When this happens, the EMDC staff then have to use their discretion to decide whether to wait for an accident and emergency vehicle in the area of the scene to become available or to extend the resource list to include vehicles further away from the scene. In this case, on the basis that a vehicle further away from the scene was not allocated to back up the PRU at the same time as the PRU was allocated, clearly it was decided to wait for an accident and emergency vehicle in the area of the scene to become available.

29. A refreshed resource list (see paragraph 28) was not generated on the Call Report until 13:17, 19 minutes after the initial resource list was generated. The resource list showed that, at 13:11, a suitable accident and emergency vehicle for this call had become 'clear'. The Manager explained to my complaints reviewer that this meant that it was available to be allocated. From my complaints reviewer's examination of the Call Report, at the time the accident and emergency vehicle became 'clear', it was about two miles from the scene (an estimated six minutes away). At 13:17, the accident and emergency vehicle was allocated to the call. By that time, the accident and emergency vehicle was 3.28 miles from the scene (an estimated seven minutes away). The accident and emergency vehicle arrived at the scene at 13:24.

30. At interview, my complaints reviewer asked the Manager about the apparent delay in allocation of the back-up accident and emergency vehicle, as it seemed that there had been a six minute period during which the accident and emergency vehicle had been available and not allocated. Also, during that time, the accident and emergency vehicle had been mobile and, as a result, had moved to a position further away from the scene. The Manager explained that, because the call was being clinically covered (by the allocation of the PRU), the allocation of vehicles to cover new incoming calls would be given priority. Only

[3] Provided that the EMDC do not select that an accident and emergency vehicle is not required to back up a PRU, which is rare (see paragraph 26).

if the PRU paramedic requested emergency assistance would the allocation of a back-up vehicle then become a priority. There is no indication from the Call Report that the PRU paramedic was in contact with the EMDC prior to the accident and emergency vehicle being allocated at 13:17 (see paragraph 12). My complaints reviewer also questioned the Manager about the risk that, during this six minute period, the available accident and emergency vehicle could have been allocated to another call. The Manager explained that it would have been of greater priority to ensure that new calls were clinically covered and that the Service has to manage competing priorities within their available staffing resources.

31. During my complaints reviewer's interview with the Manager, the visit to the EMDC and the review of the Call Report, there was no evidence to suggest that there was any warning given by the Service's system or any particular procedure for EMDC staff to follow to ensure that a back-up vehicle is allocated to a PRU. The current process appeared to rely on the EMDC staff remembering to go back into the call record on the system to allocate a back-up vehicle to a PRU.

(b) Conclusion

32. It is clear to me that Ms C recalls the accident and emergency vehicle taking longer to attend than the Call Report shows. In the absence of objective evidence to corroborate Ms C's account, I have decided to accept the Service's record as representing the accurate timings. I am satisfied that Ms C's call was received by the Service at 12:55, the accident and emergency vehicle was allocated to the call at 13:17 and arrived at the scene at 13:24. Unlike the PRU, there is no evidence to suggest any anomaly with the distance covered during the time the accident and emergency vehicle was mobile. However, I do have concerns that there was a period between 13:11 and 13:17 when the accident and emergency vehicle was available but was not allocated to the call.

33. I appreciate the reasons for prioritising new calls and the need to manage staffing resources to ensure that all calls are clinically covered as quickly as possible. However, from the point of view of a lay person, the fact that it is not a priority to back up a PRU with an accident and emergency vehicle could appear to create an unnecessarily high level of risk of delay. In this particular case, the fact that the allocation of an accident and emergency vehicle was not actively pursued until 13:17, although one became available at 13:11, created a delay. Apart from the direct delay in attendance caused by not allocating the accident

and emergency vehicle as soon as it was available, this delay could also result in the accident and emergency vehicle moving further away from the scene, as happened in this case (see paragraph 29), and possibly outwith the area altogether, or the accident and emergency vehicle could be allocated to another call. Bearing in mind the limitations of a PRU (see paragraph 25), I consider that, if the EMDC staff are not actively pursuing backing up a PRU, there is the possibility that this could result in a delay in the patient receiving specialised equipment and/or may result in a delay in a patient being transferred to hospital. Ultimately, there is a risk that a patient does not receive an appropriate level of attention from the Service and suffers as a result.

34. The Manager explained to me that it is the Service's aim to back up a PRU with an accident and emergency vehicle as soon as possible. Unfortunately, the current system being operated by the Service does not appear to support this aim. It is clear to me, therefore, that there needs to be a robust system in place to ensure that EMDC staff are aware of an outstanding requirement to back up a PRU, otherwise it could be forgotten about or continually reprioritised.

35. In this case, the accident and emergency vehicle did not arrive until almost half an hour after Ms C made her initial call. The Manager indicated to me that a reasonable response for a back-up accident and emergency vehicle would be 14 to 20 minutes (see paragraph 26). Initially, there were no other suitable or available vehicles to back up the PRU. However, when an accident and emergency vehicle became available, it was a further six minutes before it was allocated to back up the PRU. On balance, I consider that this delay was unreasonable because there is no evidence to suggest that the Service have a robust system in place to ensure that PRUs are backed up by an accident and emergency vehicle without unnecessary delay.

36. Therefore, I uphold this complaint.

37. In investigating this complaint, I have also noted concerns that the Service's policy to record all calls does not appear to extend to recording calls made from paramedics' (or other attending Service staff) mobile phones to the EMDC. This information would have been helpful in this case, as it would have provided further evidence of what actually happened and, in particular, would have confirmed the paramedic's attendance at the scene and the time.

(b) Recommendations

38. I recommend that the Service:	*Completion date*
(i) review their current system for the allocation of back-up accident and emergency vehicles to PRUs, to ensure that the risk of unnecessary delay is minimised; and	10 September 2010
(ii) consider introducing a system to record all calls from paramedics' mobile phones to the EMDC.	10 September 2010

General recommendation

39. I recommend that the Service:	*Completion date*
(i) apologise to Ms C for the failings identified in this report.	23 July 2010

40. The Service have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Service notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Service	The Scottish Ambulance Service
The PRU	The paramedic response unit
Mr A	The aggrieved, Ms C's late brother
The EMDC	The relevant Emergency Medical Dispatch Centre
The Manager	The manager of the relevant EMDC
The Call Report	The computer generated report of this specific call-out
The Satellite Report	A report based on satellite data, which showed the PRU's speed and location at various points in its journey