**Parliament Region: Lothian**

**Case 201001372: Scottish Ambulance Service**

**Summary of Investigation**

***Category***

Health: Ambulance; clinical treatment; diagnosis

***Overview***

The complainant (Mrs C) is an Independent Advice Support Services Case Worker with the Citizen's Advice Bureau. She raised a number of concerns about the Scottish Ambulance Service (SAS) on behalf of a client (Mrs A). Mrs A said that when she was out walking with her young great grandson in November 2009, she fell and broke her leg. She said a passer-by called for an ambulance (she said three calls were made) but that it took over an hour to arrive. Meanwhile, she was left in the cold. When the ambulance arrived, she was given pain relief and thus was not fully aware. Mrs A was aggrieved because her great grandson was left in the care of a person she did not know. She also complained that an inflatable splint used on her injured leg was faulty. Thereafter, Mrs C complained that the SAS failed to respond properly to the complaint she made on behalf of Mrs A.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) there was delay in responding to the 999 call (*not upheld);*
(b) the inflatable splint was faulty *(upheld);*
(c) the crew inappropriately handed Mrs A's three-year-old great grandson to an unknown person while she was incapacitated *(upheld);* and
(d) there was a failure to handle Mrs C's complaints appropriately, in that there was delay and failure to respond to all of the complaints *(upheld)*.

***Redress and recommendations***

| The Ombudsman recommends that the SAS: | *Completion date* |
|---|---|
| (i) make an addition to their Child Protection Code of Practice, to take into account circumstances where children are left in their care by virtue of the fact that the responsible adult has been taken ill or | 07 March 2011 |

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| | involved in an accident. In this regard, they may wish to refer to the Scottish Government's Guidance on Looked after Children (Scotland) Regulations 2009; | |
| (ii) | apologise to Mrs A for any distress caused as a result of allowing her great grandson to be left in the care of a stranger; | 05 January 2011 |
| (iii) | provide to him a copy of the internal auditors' report on the introduction of the pilot complaints procedure and that he is kept advised of any recommendations made; | 27 January 2011 |
| (iv) | keep him advised of the progress of the introduction of the new complaints procedure and that he receives a copy of the new complaints handling procedure; and | 05 May 2011 |
| (v) | apologise to Mrs C (and Mrs A) for the way in which the formal complaint was handled. | 05 January 2010 |

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

## Main Investigation Report

### Introduction

1. The complainant (Mrs C) is a caseworker with the Citizen's Advice Bureau. She wrote to the Ombudsman on 7 July 2010 to complain about the Scottish Ambulance Service (SAS) on behalf of the aggrieved (Mrs A). Mrs A said that on 15 November 2009, at about 10:30, when she was out walking accompanied by her young great grandson, she slipped on leaves and broke her leg. A passer-by called for an ambulance (Mrs A said three calls were made) but Mrs A complained that it took over an hour for one to arrive. Meanwhile, she was left out in the cold on wet grass. When the ambulance arrived, Mrs A said that she was given pain relief and thus she was not fully aware. She was aggrieved because her great grandson was left in the care of a person she did not know. She maintained that it was only when she later asked about the boy, as she did not know the person in whose care he had been left, that the police were called and located him. She also complained that although an inflatable splint was fitted to her injured foot, it deflated more than once during the journey to the hospital, causing her further pain. Mrs A sought Mrs C's assistance in pursuing her complaint and Mrs C complained that the SAS failed to respond to it properly.

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

(a) there was delay in responding to the 999 call;
(b) the inflatable splint was faulty;
(c) the crew inappropriately handed Mrs A's three-year-old great grandson to an unknown person while she was incapacitated; and
(d) there was a failure to handle Mrs C's complaints appropriately, in that there was delay and failure to respond to all of the complaints.

### Investigation

3. In the consideration of this case, my complaints reviewer sought information and comment from Mrs C and from the SAS. She has had sight of the SAS's complaints procedure, internal emails and action notes, crew statements and logs and their Child Protection Code of Practice. She has also spoken to the person who took charge of Mrs A's great grandson.

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

**(a) There was delay in responding to the 999 call**

5. Mrs A said that she fell at about 10:30 on the day of the accident. A passer-by called 999 for her but she said he was told that her case was not an emergency because she was conscious and was not losing any blood. She maintained that two further calls were made and she and her great grandson were left out in the cold and wet for over an hour. She said the ambulance's failure to arrive more promptly caused her additional pain and distress.

6. In relation to this aspect of the complaint, my complaints reviewer obtained a copy of the SAS call log. She also had sight of various internal briefing notes etc. These have confirmed that a 999 call was made at 11:19 on 15 November 2009. The call was made by a gentleman requesting assistance for Mrs A, who had fallen outside. The address was confirmed as X Drive, Hawick. The caller then put Mrs A on the line and, after speaking to her, the call was assessed as 'a cold response' (that is, the patient was outside and an ambulance was to be sent as soon as it became available). An ambulance was allocated to this call but was stood down when a closer crew became available at 11:21. However, this was diverted to respond to a higher priority call. Another ambulance was located at 11:23. Shortly after that (at 11:30) a further 999 call was logged, this time from a different caller who advised that the address previously given was incorrect and that the site of the accident was at Y Road, Hawick. Mrs A's condition was said to be unchanged. The records show that at 11:48 an ambulance arrived at the scene, some 29 minutes after the initial call.

*(a) Conclusion*

7. Mrs A believed that there was delay in attending to her. She said that for over an hour she was in the cold and wet. However, logs indicate that the first 999 call about the incident was made to the SAS at 11:19 and the second at 11:30. There are no records of an earlier or third call. Overall, it took 29 minutes for an ambulance to attend to Mrs A and, in light of the circumstances described above, I cannot conclude that there was a delay in responding. I do not uphold this aspect of the complaint.

**(b) The inflatable splint was faulty**

8. Mrs A said that when the ambulance arrived, the paramedics gave her gas and air. She said she passed out at this point and when she came round she was wearing an inflatable leg splint. During the journey to the hospital the splint

began to deflate which she felt allowed her broken leg to move around. She said the pain was agonising and so she was given more gas and air and also morphine. She maintained that the splint had to be inflated a further three times during the journey. Mrs A believed that the splint was faulty and, as a consequence, she suffered unnecessarily. She wanted to avoid the same thing happening to anyone else.

9. I understand that the splint used was a Ferno vacuum splint which, my complaints reviewer has been advised, is a double skinned bag with polystyrene particles between the skins. It works when the air is sucked out of the bag after it has been moulded around the fracture site. This renders the splint rigid like a plaster cast.

10. In responding to the complaints Mrs C made on behalf of Mrs A, the SAS sought information from the crew involved in transporting her to hospital. My complaints reviewer has had sight of these statements. They refer to Mrs A being given pain relief while her lower leg was immobilised with a vacuum splint. She was then transferred to the ambulance while being fully conscious and it was at this point that it was noticed that the splint had lost a little of its rigidity which required suction. It was checked again en route to ensure that it was providing adequate support.

11. After Mrs A arrived in hospital the splint was removed and checked. It was tried a few times and found to be operating perfectly. However, once back at station the splint was taken out of service as a precaution and replaced. It is understood that, on 2 December 2009, Mrs A telephoned her local SAS station as she remained concerned about it. As a consequence, the Team Leader there contacted all the local stations for all vacuum splints to be checked for deflation and leaks. The checking was carried out and all were found to be operating correctly. Mrs A received a call on 4 December 2009 advising her of this.

12. The checks that were made on the splint used on Mrs A took place immediately after she was admitted to hospital. They showed that, despite its initial failure, the splint was operating well. However, because of the problem that had occurred during the journey, crew members kept an eye on how it continued to operate. Neither crew member recorded any other problems. Nevertheless, when they got back to station, as a precaution, the splint was withdrawn. All others were also checked but no problems were found.

*(b) Conclusion*

13. For whatever reason, it is clear that the splint deflated and I have to conclude, therefore, that in some way it was faulty. It is clear that crew members remained alert to the possibility of further problems and so monitored its operation. No further problems arose but, as a precaution, the splint was later removed from use. I commend the SAS for this action and for ultimately checking all those others in use, however, in the circumstances, I uphold the complaint.

**(c) The crew inappropriately handed Mrs A's three-year-old great grandson to an unknown person while she was incapacitated**

14. Mrs A said that she passed out and when she came round in the ambulance she was wearing the leg splint. At this point she said she became aware that the little boy had been given into the care of an unknown passer-by. She became agitated and said the ambulance was stopped so that the crew could call the police to find out whether the child was safe.

15. The crew statements which my complaints reviewer has seen referred to Mrs A becoming concerned about her great grandson on arrival at hospital. They said that she did not know the person who had taken him. Consequently, calls were made to the police to locate the child. He was traced and Mrs A was told. One of the crew statements was precise about the incident and reported that a member of the public came and spoke to Mrs A and asked if she should take care of the child for her when she was taken to hospital. The statement said, 'They seemed to be familiar with each other and the PT agreed. There would have been no problem whatsoever in taking the child with the PT to hospital.'

16. As Mrs C provided the name of the person it was believed had taken the little boy, my complaints reviewer spoke directly to her. She recalled that it was when Mrs A was being treated that she had volunteered to take the child. She said that although she did not know Mrs A, she knew her daughter and family. She knew who the little boy was. She told my complaints reviewer that she took the child in her car and delivered him home to his father. When she was asked what Mrs A had said about this, she said she did not think she 'had a clue' and that she was in 'a lot of pain'. My complaints reviewer asked her about the ambulance crew, if they had said anything, but she did not recall them saying anything.

*(c) Conclusion*

17. Mrs A was in some pain. She was given entonox and morphine at various stages. A witness said that in her opinion she did not have 'a clue' about what was going on. The witness was a good Samaritan, and the crew did not seem to question this. However, circumstances could have been very different. The crew should not have allowed a child to be removed from their care and that of Mrs A, without positive, properly informed agreement from her that she was happy with the situation. I do not believe that, after her accident or having been given pain relief, Mrs A was in a position to do this. The crew should have protected her interests as far as the child was concerned. I uphold this complaint.

18. In considering this complaint, my complaints reviewer has had sight of the SAS' Child Protection Code of Practice but this was very much concerned with whether they suspected a child to be suffering from abuse, the signs to look for and what to do. It was silent on their responsibilities when they found they had a child in their care when the responsible adult was the patient. This is a systemic failure on the part of the SAS. These circumstances cannot be unusual and, accordingly, changes should be made to reflect this. I recommend that the SAS make an addition to their Child Protection Code of Practice to take into account circumstances where children are left in their care by virtue of the fact that the responsible adult has been taken ill or was involved in an accident. In this regard, they may wish to refer to the Scottish Government's Guidance on Looked after Children (Scotland) Regulations 2009. The SAS should apologise to Mrs A for any distress she was caused as a consequence of their actions.

*(c) Recommendations*

| 19. I recommend that the SAS: | *Completion date* |
|---|---|
| (i) make an addition to their Child Protection Code of Practice, to take into account circumstances where children are left in their care by virtue of the fact that the responsible adult has been taken ill or involved in an accident. In this regard, they may wish to refer to the Scottish Government's Guidance on Looked after Children (Scotland) Regulations 2009; and | 07 March 2011 |

| | | |
|---|---|---|
| (ii) | apologise to Mrs A for any distress caused as a result of allowing her great grandson to be left in the care of a stranger. | 05 January 2011 |

**(d) There was a failure to handle Mrs C's complaints appropriately, in that there was delay and failure to respond to all of the complaints**

20. On 31 March 2010 Mrs C made a complaint, on behalf of Mrs A, to the SAS. The complaint was acknowledged on 19 April 2010 and on 2 June 2010 Mrs C received a reply from the SAS Chief Executive. While this apologised for the delay in responding, the reply only addressed that part of the complaint concerning the 999 call (that is, complaint (a) above). There was no indication that a further letter dealing with the balance of the complaint was still to come or that this response was a partial one. As Mrs A was unhappy with this, she requested that Mrs C pursue her complaint with the Scottish Public Services Ombudsman (SPSO). She did so on 7 July 2010. On 27 July 2010, Mrs C received a further response from the SAS Chief Executive, again apologising for the delay in getting back to her, and dealing with Mrs A's concerns about the splint and the care of her great grandson. This letter made no reference to the Chief Executive's earlier response of 2 June 2010 or to the letter that initiated the reply (31 March 2010). It merely referred to recent correspondence.

21. My complaints reviewer has had sight of the SAS complaints process. This made reference to the fact that formal complaints were to be acknowledged within three working days of receipt and, thereafter, that the aim was to resolve all complaints within 20 working days. Where this was not possible, there was an undertaking to write to the complainant to advise them. Complainants were informed of their right to complain to the SPSO should they remain unsatisfied with the reply they receive.

*(d) Conclusion*

22. The timescales involved in responding to Mrs C's complaint indicate that the SAS failed to adhere to those they set in their commitment to complainants. This was an administrative failure. Further, the letter of 2 June 2010 was only a partial response although it did not make this clear, and another letter dealing with the remainder of the complaint was not sent until some eight weeks later. Neither of these letters responding to the complaint made any reference to the fact that Mrs C could complain to the SPSO in the event that she remained unhappy with their reply. In the light of this evidence, I uphold the complaint.

23. In responding to my enquiries on this aspect of the matter, the Chief Executive has advised my complaints reviewer that she noted that her first response to Mrs C was on 2 June 2010 which did not answer all the issues. She also said that she had tasked the SAS Head of Corporate Affairs to implement a more effective complaints system, to ensure that a more consistent and robust process was introduced. I understand that the national implementation of the system, which also includes a bespoke IT system, will be completed early next year. A pilot model is currently being audited by the SAS' internal auditors.

24. I am pleased to see that the SAS are looking rigorously at their complaints system and its operation and, in the circumstances, it is reasonable that the timetable to which they have committed is allowed to take its course. Nevertheless, I wish to be kept advised of its progress and to this end I require sight of the internal auditors' report of the pilot and of any recommendations made. Further, I wish to be kept advised of the progress of the introduction of the new complaints procedure. I note that no apology has been made to Mrs C (and Mrs A) for the way in which the complaint was handled and, accordingly, I also recommend that this be done.

*(d) Recommendations*

| 25. I recommend that the SAS: | *Completion date* |
|---|---|
| (i) provide to me a copy of the internal auditors' report on the introduction of the pilot complaints procedure and that I am kept advised of any recommendations made; | 27 January 2011 |
| (ii) keep me advised of the progress of the introduction of the new complaints procedure and that I receives a copy of the new complaints handling procedure; and | 05 May 2011 |
| (iii) apologise to Mrs C (and Mrs A) for the way in which the formal complaint was handled. | 05 January 2011 |

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

**Annex 1**

**Explanation of abbreviations used**

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| Mrs C | The complainant |
| Mrs A | The aggrieved |
| SAS | Scottish Ambulance Service |