Scottish Parliament Region: Lothian

Case 200901107: Scottish Ambulance Service

Summary of Investigation

Category

Health: Ambulance; diagnosis; clinical treatment; complaint handling

Overview

The complainant (Ms C) raised concerns on behalf of her client (Mrs B) that a Scottish Ambulance Service crew failed to recognise the seriousness of her daughter (Ms A's) condition when they responded to Mrs B's emergency telephone call. This resulted in a delay in transferring Ms A from Mrs B's home to the hospital with fatal results. Ms C was also dissatisfied with how the Scottish Ambulance Service (the Service) had dealt with this complaint.

Specific complaints and conclusions

The complaints which have been investigated are that the Service:

(a) failed to provide appropriate care and treatment to Mrs B's daughter (*upheld)*; and

(b) delayed in investigating the matter and failed to keep Mrs B updated *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Service:	*Completion date*
(i) review the protocol for ambulance crews to ensure it gives clear guidance to staff about the relative roles of different crew members in the assessment of patients;	15 June 2011
(ii) assess this protocol to demonstrate and evaluate that it is properly understood by ambulance crew;	13 July 2011
(iii) ensure that measures are undertaken to feedback the learning from this incident to avoid similar situations recurring;	15 June 2011
(iv) review their methods for learning from complaints and introduce comprehensive, dated action plans for follow-up action specific to each complaint;	13 July 2011

(v)	introduce a method of ensuring that any wider learning from complaints is fully integrated into the governance structure of the Service; and	13 July 2011
(vi)	issue Ms C and Mrs B with a formal written apology for the failures identified in this report.	1 June 2011

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

Main Investigation Report

Introduction

1. Ms C assisted Mrs B with her complaint against the Scottish Ambulance Service (the Service) regarding the incident which took place on 7 October 2008, when Mrs B's daughter (Ms A) became suddenly and unexpectedly ill at Mrs B's home. Ms A had complained of severe breathing difficulties and an emergency ambulance was called. An ambulance crew – a paramedic (Paramedic 1) and a technician (the Technician) - arrived at Mrs B's home ten minutes later. The crew who attended Ms A thought she was suffering a panic attack and began treating her for this. Ms A subsequently collapsed and the crew commenced resuscitation. Paramedic 1 called for backup to assist with a cardiac arrest. Another paramedic (Paramedic 2) arrived nine minutes later. Ms A was resuscitated, transferred to the ambulance and driven to hospital while resuscitation continued. Mrs B travelled to the hospital independently with Paramedic 2. They arrived at the same time as Ms A's ambulance. Mrs B was asked to go straight to the relative's room and to telephone home for someone to wait with her. Shortly afterwards Mrs B was told by hospital staff that Ms A had died from a pulmonary embolism.

2. Following Ms A's death, Mrs B considered that the ambulance crew should have recognised the seriousness of Ms A's condition immediately they observed her. Mrs B believed that had they done so Ms A would have been transferred to hospital sooner and this may have saved her life. Mrs B contacted Ms C, who complained to the Service on 21 May 2009 and received a number of responses from them – the final response was on 4 March 2010. Ms C was concerned that the Service had delayed in responding to her and also had not kept her and Mrs B properly informed. On 28 May 2010 Ms C, on behalf of Mrs B, raised a complaint with the Ombudsman, seeking a full investigation into what had happened.

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

(a) failed to provide appropriate care and treatment to Mrs B's daughter; and

(b) delayed in investigating the matter and failed to keep Mrs B updated.

Investigation

4. In investigating the complaint, my complaints reviewer had access to a detailed written statement by Mrs B which was submitted by Ms C at the time she complained to the Service in May 2009 (the Statement). My complaints

reviewer sought information and comment regarding the complaint from a medical adviser to the Ombudsman (the Adviser) and from the Service. She has had sight of the Service complaint investigation, internal emails and action notes. This included statements taken from Paramedic 1, the Technician and Paramedic 2 on 18 June 2009, after Ms C had complained to the Service. My complaints reviewer has also reviewed the detailed computerised log of the relevant ambulance telephone calls and the Patient Report Form, which recorded details of the Service attendance on Ms A.

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, Mrs B and the Service were given an opportunity to comment on a draft of this report. Abbreviations are set out in Annex 1 and Annex 2.

(a) The Service failed to provide appropriate care and treatment to Mrs B's daughter

6. Ms A died from a pulmonary embolism (PE). PE happens when a blood clot gets trapped in one of the blood vessels in the lungs. The clot forms somewhere else in the body and is carried to the lungs through the blood supply. The clot can have a number of origins, however, it most often forms in one of the deep veins that run through the legs. A clot in one of these veins is called deep vein thrombosis (DVT). There are many symptoms of PE, including severe chest pain, coughing up blood, breathing difficulties and a red painful leg (which may indicate a DVT). PE varies enormously in severity and can also be symptom-less. The symptoms of PE can be similar to a number of other conditions and it may be misdiagnosed because of this. The treatment for PE will vary according to the severity of the condition. PE is classified as either massive or submassive. A massive PE requires immediate, emergency and substantial medical treatment with oxygen, medication to maintain blood pressure and drugs to treat the clot in the blood or possibly surgery. Massive PE is the second highest cause of sudden unexpected death.

7. In her Statement (see paragraph 4) Mrs B described the arrival of the ambulance crew in Ms A's upstairs bedroom. She gave them an account of Ms A's condition and, in particular, removed Ms A's left sock to show her foot and leg, which Mrs B thought was swollen and 'a weird colour'. Mrs B stated that at this point the crew told Ms A she was having a panic attack and appeared to be deliberating what to do. They gave Ms A an oxygen mask to hold. Ms A then began to sweat profusely and told Mrs B she was going to be

sick. Mrs B left the room to get a basin. One of the ambulance crew went back to the ambulance at this time. When Mrs B returned into the bedroom, Ms A had collapsed and the remaining crew member asked Mrs B for assistance to put Ms A on the floor and then asked that she call his colleague to return, which she did. Mrs B was asked to remain outside while the two crew members resuscitated Ms A.

8. As part of the Service Investigation, the Technician was interviewed and a statement taken. It was recorded that the Technician said he had entered the bedroom first with Paramedic 1 behind him. He stated he was aware that they had not brought the defibrillator (a machine which administers a controlled electric shock to the chest or heart to correct a critically irregular heartbeat which cannot drive the circulation) from the ambulance with them, however, he had not commented on that to Paramedic 1. The Technician said he began taking a medical history from Mrs B. In his view, Ms A was having a panic attack and he advised Ms A of this. He recalled Mrs B showing them Ms A's foot and that he had given Ms A an oxygen mask. The mask was not then connected to an oxygen supply, however, it was to help her regulate her own breathing in the same way as breathing into a paper bag might do. The Technician stated that because of Ms A's foot, which Mrs B said was swollen and sore and could not weight bear, he believed Paramedic 1 left the room to get the chair and blanket to transport Ms A to the ambulance. He remembered that Ms A then complained of back pain and he started to administer oxygen through the mask. At this point Ms A collapsed. He then checked for vital signs and detected a pulse in Ms A's neck but noted that she was not breathing. He asked one of the household to contact Paramedic 1 immediately to bring the defibrillator from the ambulance while he inserted an airway necessary for resuscitation. Paramedic 1 arrived, secured the airway and they both commenced resuscitation procedures. Resuscitation took approximately 20 minutes, during which time Paramedic 2 arrived to assist them (see paragraph 1). Paramedic 1 and Paramedic 2 then lifted Ms A down to the ambulance with the airway secured in place. The Technician went behind to support ventilation and maintain the airway. He then returned to the room to collect equipment, while Paramedic 1 and Paramedic 2 secured Ms A in the ambulance.

9. From their respective statements, Paramedic 1 (the driver on the day) and the Technician (the attendant on the day) gave overall similar accounts of events. Paramedic 1 stated that he entered the room behind the Technician

and was not able to hear Mrs B very well because the space in the room was very tight. He recalled the Technician taking a few minutes to get a history from Mrs B and that he had also asked some questions of Mrs B. He did not have the defibrillator with him and stated the nature of the original callout had not indicated this would be needed. Paramedic 1 stated that he told the Technician he would go and get the chair from the ambulance. At that time, Paramedic 1 said Ms A was conscious and talking and her colour appeared good. She was also on oxygen. While at the ambulance, he was told by a male member of the household that the Technician needed the defibrillator. He realised they would need help so he radioed the Emergency Medical Dispatch Centre for assistance. The computerised log indicates that this call occurred at 14:54, 14 minutes after the crew arrived at Mrs B's house at 14:40. This arrival time is also recorded on the Patient Report Form.

10. During their investigation of Ms C's complaint the Service identified two failures in the actions of Paramedic 1 and the Technician. Firstly, the defibrillator (as part of the initial first response equipment), should have been taken into the house when the crew arrived. According to the Service, it may have assisted the crew in their assessment of Ms A's condition as it gives an indication of oxygen levels in the blood. This would have alerted them to the seriousness of Ms A's condition before her collapse. The second failing the Service outlined was the failure of both crew members to recognise, in good time, the potential seriousness of the combination of symptoms Ms A presented which led to a delay before they arranged for Ms A's transfer to hospital. The Service acknowledged that early on in the incident, Paramedic 1 and the Technician had made an assumption that Ms A had been suffering from a panic attack and had treated the incident as a panic attack. This was stated by the Service as the reason for the delay in transporting Ms A to the hospital.

11. The Service investigation culminated in their report, dated 7 July 2009, which stated that there appeared to be inconsistencies in the statements given by Mrs B, Paramedic 1 and the Technician, specifically, inaccuracies which related to the timings of events. They attributed these inaccuracies to the delay in Mrs B reporting the incident (see paragraph 4) and Paramedic 1 and the Technician also having conflicting memories of the timing of events.

12. Mrs B was advised of the outcome to her complaint in a letter dated 11 August 2009 from the Service to Ms C. She was further advised that both the crew members who initially attended Ms A would be referred to the Head of

Service for consideration of possible disciplinary action. This issue will be fully addressed in complaint (b).

13. The Adviser reviewed the case file which included the Service records and logs, along with Mrs B's account of events. He stated that most of the evidence he had seen dated from April 2009, some seven months after Ms A's death. He noted that the Service had identified two important problems (see paragraph 10), however he expressed concern that the Service did not appear to have given consideration to the broader implications of this incident. He was concerned that, although the Service investigation acknowledged that the attending Service crew failed to identify a possible PE, their investigation did not pick up any larger significance of Ms A's foot pain as a significant symptom. The Adviser stated, 'Chest pain and breathlessness with a swollen foot is caused by a PE (with a causative DVT) until proved otherwise. This is an extremely serious situation which can result in collapse and death as happened here'. The Adviser stated that early assessment in hospital and treatment with anti coagulants may have led to a different outcome and that the assessment of Ms A could have been improved.

14. The Adviser also considered that the original missed diagnosis and lack of emphasis in the Service investigation, suggested a wider lack of awareness of PE in the Service's service provision. He was disappointed that no consideration had been given by the Service to ensure that all ambulance crew were aware of the significance of symptoms of the possibility of PE. This issue will be considered further in complaint (b).

15. The Adviser also expressed concern that the lead clinician in this case was taken by the Technician (see paragraph 8). Paramedic 1, who could be expected to be more aware of the significance of the swollen foot as an additional symptom, had stated he was unable to hear much of what was being said and had left his colleague to take the lead (see paragraph 9). My complaints reviewer asked the Service to comment on the relative roles of technicians and paramedics in assessing patients. In their response of 10 August 2010, they stated '[the Service] would expect a Paramedic as a more comprehensively trained clinician to take the lead on the assessment'. In their response, the Service also provided general comments on the role of their frontline technicians and paramedics.

16. The Adviser considered this response and commented on the importance of picking up clues as it changes the analysis of risk. For example, he stated that in this case the swollen 'possibly bruised foot' markedly increased the possibility of a PE and thus the need for a speedy admission. The Adviser said that the Service had not mentioned this in their response letters and he did not consider it was given much importance in the interviews with the crew.

(a) Conclusion

17. The personal accounts considered in this case were given several months after the events in question. The accounts cannot be matched completely either to each other or to the computerised records that were made at the time. These differences signify that it is not possible for me to know for certain the exact flow of events. However, this lack of certainty has not impacted on my ability to review Ms C's concerns about the timeliness of diagnosis and treatment given to Ms A by the attending crew. The key times relevant to this complaint can be ascertained from the computerised log when the crew arrived at Mrs B's house at 14:40 and called for assistance following Ms A's collapse at 14:54 (see paragraph 9).

18. Beyond the two crucial failures already identified in the Service investigation – the lack of the defibrillator on arrival and the failure to assess the seriousness of Ms A's condition (see paragraph 10) - I have also found a further failure by the crew in having the Technician rather than Paramedic 1 take the lead on assessment. The Adviser stated that this did not represent good medical practice and the Service have also acknowledged that this did not meet their expectation of what should have occurred. Accordingly, taking all these factors into account, I uphold Ms C's complaint that the Service failed to provide appropriate care and treatment to Ms A.

(a) Recommendations

19. I recommend that the Service:	*Completion date*
(i) review the protocol for ambulance crews to ensure it gives clear guidance to staff about the relative roles and responsibilities of different crew members in the assessment of patients;	15 June 2011
(ii) assess this protocol to demonstrate and evaluate that it is properly understood by ambulance crew; and	13 July 2011

(iii) ensure that measures are undertaken to feedback the learning from this incident to avoid similar situations recurring in the future. 15 June 2011

(b) The Service delayed in investigating the matter and failed to keep Mrs B updated

20. Ms C complained to the Service on 21 May 2009. This was received on 22 May 2009 and acknowledged by the Service Head of Services on 27 May 2009. Ms C received a holding letter dated 24 June 2009 advising that the investigations were taking longer than hoped, however, a full response would be sent as soon as possible. The Service files indicated that the staff interviews took place on 18 June 2009 and the investigator's report was ready from 3 July 2009 and approved by the Head of Service on 7 July 2009. There was no obvious reason within the Service documents for the written complaint response not being sent to Ms C until 11 August 2009.

21. In her letter dated 8 September 2009 to the Service, Ms C raised a number of questions which emanated from their response of 11 August 2009. These questions were answered in part by the Chief Executive's reply dated 5 November 2009. This response prompted further questions from Ms C in her letter to the Service dated 2 December 2009. This letter was received on 9 December 2009, however, it was not acknowledged or responded to until the matter was pursued by Ms C's telephone contact with the Service on 24 February 2010. The Service have not been able to provide an explanation why this letter was overlooked and not responded to.

22. I have seen, in her letter of 8 September 2009, that Ms C was concerned that the response of 11 August 2009 indicated that the staff concerned were only now being referred for possible disciplinary action. She raised questions about why this had taken so long and what was actually being done. The Service records included a reference to this question and an entry stated that it was not appropriate for a complainant to be advised of the outcome of any disciplinary action.

23. The Service investigation files contained several summaries by officials involved in reviewing this complaint. These summaries included a number of recommendations as to future actions arising from the original investigation and in a case review in September 2009, for example:

- 'It is recommended that both staff members [Paramedic 1 and the Technician] should receive refresher training on Patient Assessment to reduce the risk of misdiagnosis, in particular Pulmonary Embolism'
- 'Clarification around training on initial response equipment to be taken into incident'
- 'Health Professional Council Code of Conduct states a Paramedic is responsible for tasks carried out by a non registered Ambulance crewed together.'

24. This last point was precisely the concern identified by the Adviser in complaint (a) (see paragraph 15), however it did not form part of the response to Ms C or in the action taken by the Service (see paragraphs 12 and 14).

(b) Conclusion

25. There were clearly inexplicable delays in the handling of this complaint, both related to the original Service response letter and their response after 2 December 2009. The NHS complaints process requires that a full response is made within 20 days following the receipt of a complaint, however it does permit for a holding letter to be sent to allow for additional time for more complex cases. In this instance it may not have been possible to respond to Ms C's initial complaint within the 20 days, however, the response should have been given a higher priority and could have been sent before 11 August 2009 (see paragraph 20). The delay that occurred following receipt of Ms C's letter dated 2 December 2009 is also unacceptable.

26. Ms C's concerns were only in part about the time taken to respond to the complaint. More significantly, she was concerned that failings had occurred on 7 October 2008 and had been identified; however, nothing appeared to have been done to address these failings for the future. I share her concerns.

27. The Service did not respond to Ms C's question about disciplinary action or clarify this point. This was wrong on two counts. The complainant is entitled to know why they cannot have their question answered. It is not acceptable that a question is simply ignored, as happened here. Also, the Service were incorrect in their analysis of what Ms C could or could not be told. It is correct that questions of staff discipline are not for the complaints process and cannot be shared with complainants. However, much of what was identified by the Service investigation and the action to be undertaken was not a question of disciplinary action, but rather of ensuring that the crew concerned learned from

the failings identified, by the crew participating in a clinical case review with a divisional clinical lead. This was to ensure they understood the symptoms of PE and their significance, and had an awareness of the importance of taking all equipment for initial assessment into a house on arrival. This was not a disciplinary matter and it would have greatly assisted Ms C to know such action was being taken.

28. I am further concerned at the lack of any comprehensive scheme to ensure that there is institutional as well as personal learning from complaints and to ensure that such learning happens promptly. The Service reviews did identify several significant issues, however there was no planned learning as a consequence of these. Such a failure to learn from complaints is a missed opportunity to prevent future problems arising and causes me considerable concern.

29. I have identified a number of failings and errors and uphold Ms C's complaint about the timeliness and quality of the Service investigation of her complaint.

(b) Recommendations

30. I recommend that the Service:	*Completion date*
(i) review their methods for learning from complaints and introduce comprehensive, dated, action plans for follow-up action specific to each complaint;	13 July 2011
(ii) introduce a method of ensuring that any wider learning from complaints is fully integrated into the governance structure of the Service; and	13 July 2011
(iii) issue Ms C and Mrs B with a formal written apology for the failures identified in this report.	1 June 2011

31. 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	Citizens Advice Bureau officer, acting on behalf of Mrs B
Mrs B	The complainant, mother of Ms A
Ms A	The aggrieved, daughter of Mrs B
Paramedic 1	A paramedic who was part of the two man crew who first attended Ms A
The Technician	An ambulance technician who was part of the two man crew who first attended Ms A
Paramedic 2	A paramedic who attended Ms A as a result of a request for assistance from Paramedic 1
The Service	The Scottish Ambulance Service
The Adviser	A medical adviser to the Ombudsman

Annex 2

Glossary of terms

Deep Vein Thrombosis (DVT)	A clot which forms in one of the deep veins of the leg
Defibrillator	A machine with an inbuilt ECG (heart rate) reader, which the ambulance crew can use to assist in diagnoses and also to supply a therapeutic electric shock if required
Pulmonary Embolism (PE)	A blood clot which travels to the lungs and causes an obstruction in the blood vessels there