**Scottish Parliament Region: Lothian**

**Case 201103310: Scottish Ambulance Service**

**Summary of Investigation**

***Category***

Health: Scottish Ambulance Service; delay

***Overview***

The complainant (Mrs C) raised concerns about the length of time it took for an accident and emergency vehicle to attend an emergency at home when her husband, Mr C, became gravely unwell and how the Scottish Ambulance Service (the Service) handled her complaint.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) the delay in ambulance's arrival was unreasonable (*upheld*); and

(b) the handling of the complaint was unreasonable (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Service: | *Completion date* |
|---|---|
| (i) report back to the Ombudsman on what additional support is provided to less experienced call handling staff; | 20 March 2013 |
| (ii) carry out a review involving the software provider to ensure that the software issue is re-assessed; | 20 March 2013 |
| (iii) review their complaints handling in light of the failings identified; and | 20 March 2013 |
| (iv) provide Mrs C with a full apology for the failures that occurred on 15 October 2010. | 20 March 2013 |

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

## Main Investigation Report

### Introduction

1. On 15 October 2010 at 03:39, Mrs C called the Scottish Ambulance Service (the Service) requesting an ambulance for her husband, Mr C, who was in severe difficulties. Mrs C gave the address to the call taker. At 03:56, the ambulance crew told the emergency medical dispatch centre that they could not locate the address. Mrs C gave further details to the call taker which was passed onto the crew. The crew arrived at 04:03, 24 minutes after mobilisation. (Mrs C's house is minutes away from where the ambulance was dispatched). Mr C died at some point on 15 October 2010.

2. When making her complaint to the SPSO, Mrs C stated that she remains extremely distressed about the ambulance's delay. She accepted that Mr C might still have died even if the ambulance arrived within a reasonable time, but she could not move on until she receives a clear explanation on what went wrong and reassurance that it would not happen again.

3. Mrs C complained to the Service by telephone shortly after Mr C died on 15 October 2010 and expected a written response. On 15 August 2011, representatives of the Service visited Mrs C. The Service sent their formal response to Mrs C on 7 October 2011.

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

(a) the delay in ambulance's arrival was unreasonable; and

(b) the handling of the complaint was unreasonable.

### Investigation

5. During the course of the investigation of this complaint, my complaints reviewer obtained and examined a copy of the Service's records relating to Mrs C's telephone calls including their complaint file. She also made enquiries of the Service and obtained advice from an adviser specialising in general practice to the Ombudsman (the Adviser) on the clinical aspects of the complaint.

6. 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 Service were given an opportunity to comment on a draft of this report.

*Enhanced information service for emergency calls (EISEC)*

7. EISEC is a system whereby all the information about the location of the calling telephone is transmitted electronically to, in this case, the Service. This database holds all the addresses for the subscribers to the software provider. When somebody calls 999 from a software provider landline, the telephone number will show in the system, which will return the address details from the database that the telephone number is registered to.

**(a) The delay in ambulance's arrival was unreasonable**

8. Mrs C said that on 15 October 2010, she was woken sometime after 03:00 by the sound of Mr C making a very loud noise. She called 999 and asked for an ambulance. The call taker took details of Mrs C's address. Mrs C stayed on the telephone to the call taker and followed their instructions regarding Mr C. After 20 minutes, Mrs C commented to the call taker that the crews must be out on calls because she only lived two minutes from the station. The call taker took further details about Mrs C's address and the ambulance arrived shortly after.

*The Service's response*

9. The Service first apologised for the delay in responding to Mrs C's complaint and offered condolences for the loss of her husband. The Service went on to say that the head of ambulance service to that crew and the emergency medical dispatch centre (EMDC) duty manager visited Mrs C to discuss the incident on 15 October 2010. The duty manager investigated Mrs C's complaint. A 999 call was received at 03:39 and an ambulance was mobile at 03:39 arriving at Mrs C's address at 04:03. The duty manager said that the call taker did not effectively register details of Mrs C's address. The call taker should have entered additional details which Mrs C provided on several occasions during the call into the system. A warning to highlight information which alerts vehicle crew staff was entered on the system. This warning stated the correct location, but the warning was removed at 03:39. At 03:56: the ambulance crew informed the EMDC of their difficulty in locating the address and Mrs C provided further directions. The information was entered into the system and passed to the crew. Immediately following the incident, the EMDC shift supervisor entered Mrs C's address into the system and found that it was not registered in the index. There is a process for updating the index and Mrs C's address details were entered. Two recommendations have been carried out: all staff received refresher training on methods of address search with specific coaching and development for the call taker; and staff were

reminded of the importance of recording all relevant information passed by callers in relation to address details. The Service apologised for not giving Mrs C feedback when she initially raised her complaint as they said they would and that she had cause to complain.

10. In response to enquiries by my complaints reviewer, the Service said that on 15 October 2010, Mrs C's address did not feature in the system. When the address given by Mrs C was entered into the system, it showed as a different address in a different location. (This had now been rectified.) A warning is put on the system by the call taker to alert the dispatcher to something important. In this case, the warning was that the address the system showed was incorrect. The call taker highlighted the proper address and put a warning on to that effect. The dispatcher will switch off the warning once they have taken note of it so that further warnings that may go on can be easily identified. On this occasion, the dispatcher switched the warning off once they had allocated the crew and advised them of the correct details. However, the crew then called to say that they were having difficulty finding the address. Further information about the address was taken from Mrs C and entered into the system, again as a warning. This information was then passed to the crew and they reached the correct address. The Service also said that the call taker was relatively new.

11. The Service's complaint file shows that one of the recommendations made as a result of their investigation was that less experienced call handling staff are provided with a greater degree of support.

*Advice received*

12. My complaints reviewer asked the Adviser what impact, if any, the delay had on the outcome. The Adviser said that he did not believe the delay would have changed the outcome for Mr C.

*(a) Conclusion*

13. Mrs C complained that the delay in the ambulance's arrival was unreasonable. The Service attributed the delay to failures in the system and by the call taker. It is clear that a combination of factors - the known issues within the software, the failures by the call taker and the fact that the first warning was switched off - meant that the crew had difficulty in finding Mrs C's address and the resulting delay was not reasonable. The advice I have accepted is that the delay would not have changed the outcome for Mr C. However, the failures by the Service led to a significant personal injustice to Mrs C in that the delay

exacerbated what was a very traumatic experience. I uphold the complaint. I am concerned that the factors that caused this situation to arise have not been fully addressed. Given this, I recommend that the Service carry a further review to ensure that this does not happen again and report back to me.

*(a) Recommendation*

| 14. I recommend that the Service: | *Completion date* |
|---|---|
| (i) report back to the Ombudsman on what additional support is provided to less experienced call handling staff; and | 20 March 2013 |
| (ii) carry out a review involving the software provider to ensure that the software issue is re-assessed. | 20 March 2013 |

**(b) The handling of the complaint was unreasonable**

15. Mrs C complained to the Service by telephone shortly after her husband died and expected a written response from the supervisor. She got no response. She wrote to the Service on 4 March 2011 seeking a written response to her complaint. Representatives of the Service visited Mrs C at home on 15 August 2011. The Service sent their formal response to Mrs C on 7 October 2011. Mrs C complained about the delay and the response itself which she did not understand.

*The Service's response*

16. See paragraph 9.

*(b) Conclusion*

17. Mrs C complained that the handling of her complaint by the Service was unreasonable. It is clear that the Service attempted to explain what was a complex problem in their response. However, it was overly technical and the Service failed to apologise for the significant shortcomings they had identified which led to an unreasonable delay in ambulance's arrival. The Service also failed to acknowledge and apologise for the significant distress that this caused Mrs C. There was also a significant delay by the Service in their complaints handling. The Service told Mrs C they would provide feedback shortly after she contacted them. However, the Service failed to contact Mrs C until she wrote to them four months later. It was only then that the Service undertook an investigation into what happened. It took a further four and a half months before they visited Mrs C and then they wrote to her just under two months later with the findings of their investigation. Overall, it took nearly a year to issue

their formal response. This is unacceptable and insensitive, as is the delay in investigating. Given the nature of the complaint, the Service should have investigated as a priority to ensure that any systems failures in the emergency callout service were rectified. I uphold the complaint.

*(b) Recommendations*

| 18. I recommend that the Service: | *Completion date* |
|---|---|
| (i) review their complaints handling in light of the failings identified; and | 20 March 2013 |
| (ii) provide Mrs C with a full apology for the failures that occurred on 15 October 2010. | 20 March 2013 |

19. 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**

| | |
|---|---|
| Mrs C | The complainant |
| The Service | Scottish Ambulance Service |
| Mr C | The complainant's husband |
| The Adviser | A professional specialist general practitioner adviser to the Ombudsman |
| EISEC | Enhanced information service for emergency calls |
| EMDC | Emergency medical dispatch centre |