Scottish Parliament Region: Lothian

Case 201301204: Scottish Ambulance Service

Summary of Investigation

Category

Health: Ambulance; clinical treatment; diagnosis

Overview

The complainant (Mrs C) complained on behalf of her husband, Mr C. She said that after Mr C fell down the stairs at home and an ambulance was called, staff failed to ensure that he was properly cared for. She believed that the actions of the paramedics contributed to his resultant paraplegia (complete paralysis of the lower half of the body including both legs, usually caused by damage to the spinal cord).

Specific complaint and conclusions

The complaint which has been investigated is that the Scottish Ambulance Service (the Service) failed to ensure that their staff used a stretcher and neck brace when transferring Mr C to hospital *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Service:	*Completion date*
(i) make a formal apology to Mr and Mrs C for their failure to properly immobilise Mr C after the incident on 24 March 2012 and for the inadequacies of their internal investigation; and	23 April 2014
(ii) externally audit their complaints handling processes to ensure that they are sufficiently robust and fit for purpose.	24 September 2014

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

Main Investigation Report

Introduction

1. Mrs C complained on behalf of her husband (Mr C). She said that on 24 March 2012, Mr C fell down the stairs. He had been out with friends and had been drinking. An ambulance was called, which appeared promptly, but Mrs C said that the paramedics involved made unprofessional, judgemental statements about Mr C. She maintained that their opinion of Mr C affected the care provided to him and she complained that despite his fall, he was transferred to the ambulance by wheelchair. She said that he should have been treated for the worse-case scenario and should have been laid on a stretcher with his neck in a brace. Mrs C alleged that the paramedics' actions may have contributed to his resultant paraplegia (complete paralysis of the lower half of the body including both legs, usually caused by damage to the spinal cord).

2. The complaint from Mrs C which I have investigated is that the Scottish Ambulance Service (the Service) failed to ensure that their staff used a stretcher and neck brace when transferring Mr C to hospital.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including all the complaints correspondence and documentation provided by the Service. This has been given careful consideration. Independent advice has been obtained from an experienced registered paramedic (the Adviser) and this has also been taken into account.

4. While this report does not include every detail investigated, 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.

Complaint: The Service failed to ensure that their staff used a stretcher and neck brace when transferring Mr C to hospital

5. Mrs C said that on 24 March 2012, after having a drink with them, Mr C was brought home by friends at approximately 18:40. He went upstairs to use the lavatory but on hearing a loud bang, Mrs C found him lying at the bottom of the stairs. She said that he was unconscious and having great difficulty breathing. Although she said she tried to move him to assist with his breathing, she was unable to do so and called her son to help. Together, they moved him to the living room and called an ambulance.

6. Mrs C said that the ambulance arrived promptly but that the crew seemed initially reluctant to take Mr C to hospital. She said they only did so because his blood pressure was low but she overheard them making comments about 'drunks'. Mrs C was annoyed because she said these comments were completely unprofessional and their judgemental attitude affected the way they treated Mr C. In the meantime, Mrs C said that Mr C was transferred to a wheelchair and taken to the ambulance but that the staff concerned failed to ensure that he was treated for the 'worst case scenario', that is, on a stretcher wearing a neck brace. Mrs C said that because Mr C had been drinking alcohol, he was treated as a nuisance rather than the injured person he clearly was. She believed that the action of staff contributed to Mr C's paralysis.

7. Mr C was transferred to hospital but the next day was found to have no movement in his legs. Mr C is now paraplegic.

8. On 7 May 2012, Mrs C complained to Fife NHS Board about the care that had been given to Mr C generally, including by the Service and other organisations involved in his care and treatment.

9. The Chief Executive of the Service replied to Mrs C directly on 11 September 2012 although, in the meantime, telephone contact was made with her on 21 June 2012 and she and her son were visited at her home on 26 June 2012 by the General Manager of the East Central Area (the Manager), who was acting as Investigating Officer. The Chief Executive said she was sorry to hear of the distress the ambulance crew had caused Mrs C and for her delay in replying. She said that the matter would be 'taken forward in accordance with the Service's Policies and Procedures' but that if Mrs C was unhappy with the way her complaint had been dealt with, it was open to her to complain to my office. Mrs C did so on 21 May 2013.

10. As part of the investigation of this complaint, my complaints reviewer obtained advice. The Adviser was asked specifically what should have happened when the ambulance crew attended Mr C. The Adviser said that on arrival at Mr and Mrs C's house (recorded as being at 19:55), it would have been reasonable for staff to complete a rapid primary survey. She said that an Electronic Patient Report Form (the EPRF) was completed at the time of the incident and this detailed the primary assessment. It was recorded that Mr C's airway was clear; he was responding to verbal prompts; and his skin was

observed to be pale and dry. The Adviser commented that it was unclear from the EPRF what time these clinical findings were observed and recorded. She further noted that although the ambulance crew arrived on the scene at 19:55, there was no documented evidence of Mr C's clinical observations at this time. She said the first clinical observations were not completed/recorded until 20:12.

11. The Adviser went on to say that once a patient's vital signs were established within the primary survey, the Joint Royal Colleges Ambulance Liaison Committee, Neck and Back Trauma Guidelines, 2006 (the Guidelines) stated that, 'it is vital to determine the mechanism of injury in order to understand the forces involved in causing the injury'. She said the EPRF recorded that Mr C had fallen down approximately ten stairs and had been unconscious for five minutes. However, the mechanism of Mr C's injury was not clear to the ambulance crew when they arrived because Mrs C and her son had moved him. Nevertheless, she said despite this the significance of a fall down ten stairs resulting in a period of unconsciousness should have been clear to them. In so far as the Guidelines were concerned, the Adviser pointed out that they stated that the presence of ALL of the following criteria can exclude significant spinal injury:

- normal mental status;
- no neurological deficit;
- no spinal pain or tenderness;
- no evidence of intoxication;
- no evidence of extremity fracture.

12. She said that spinal injury could not be excluded as there was evidence that Mr C had been drinking and that his mental status was altered. She also noted that his Glasgow Coma Score (GCS) was recorded on the EPRF at 20:13 as 8 and at 20:16 it was 11. GCS is the numeric value used in all clinical settings to establish the level of consciousness in a patient. A GCS of 15 means that a patient has no impairment and a GCS of 3 means that a patient is unconscious.

13. The Adviser said that it was her view that had the crew adequately established the mechanism of injury and recognised the significance of a reduced level of consciousness, and the relevance of Mr C being intoxicated, they should have concluded that they could not exclude spinal injury. She went on to say that the Guidelines stated that all patients with the possibility of spinal

injury should have manual immobilisation applied at the earliest opportunity. Furthermore, the Adviser said she found no evidence to suggest that the ambulance crew attempted to discount other symptoms that a patient with a suspected spinal injury may have (for instance, neck or back pain, loss of sensation in the limbs, loss of movement or sensation of burning or electric shock in the trunk of limbs) by further physical examination. The Adviser said that the EPRF did not feature any evidence that Mr C was assessed for any of the clinical signs of spinal injury.

14. The Adviser referred also to some vital clinical observations such as blood pressure, pulse rate and respiratory rate as being either missing or unreadable from the record. It was her view that the ambulance crew should have assessed Mr C's blood pressure (to which Mrs C referred, see paragraph 6) pulse rate and carried out a breathing assessment, to determine both breathing rate and adequacy of breathing. She said that capillary refill assessment was recorded as less than two seconds and Mr C's oxygen saturation was recorded at 100 percent although oxygen was recorded as being administered at 85 percent. It was unclear to her whether the oxygen saturation measurement was established before or after the administration of oxygen.

15. In summary, the Adviser was of the opinion that when they first arrived on the scene, the ambulance crew should have been alert to the fact that Mr C had experienced a significant fall. Once the mechanism of the fall had been established (from Mrs C and her son), coupled with the decreased level of consciousness and apparent alcohol intoxication, manual spinal immobilisation should have been applied at the earliest opportunity. It was not.

16. Mrs C complained about Mr C's treatment by the Service on 7 May 2012 and the Chief Executive replied to her on 11 September 2012 (see paragraph 9). Amongst other things, this letter apologised to Mrs C for the distress the ambulance crew had caused her and gave an assurance that the matter would be taken forward in accordance with the Service internal procedures. As part of this investigation, my complaints reviewer requested (on 9 August 2013) all the relevant correspondence and documentation relating to this complaint in order to establish the evidence obtained by the Service in their own investigation which led them to this conclusion. Then, by letter of 3 September 2013, my complaint reviewer specifically sought staff statements, a note of the visit to Mrs C (see paragraph 9) and a direct response to the terms of this complaint (as the Service had not made any definitive statement about

the complaint being investigated). On 9 September 2013, the Corporate Affairs and Complaints Officer replied saying:

> 'The ASM [the Manager] spoke with the crew and wrote a hand written statement which he took to the visit to [Mrs C]. This was clarified and signed by [Mrs C]. I have attached this document. There are no other staff statements.'

17. All the documentation provided by the Service was taken into account as part of this investigation. The Adviser was of the view that it was incomplete. She commented that the handwritten note stated that the meeting with Mrs C was commenced on 29 June 2013 (but see paragraph 9) although Mrs C's signature was recorded on 27 June 2013. She said that none of these dates were consistent with those noted in the Formal Complaint Investigation Report (the Report) which was provided by the Service. The Adviser also added that the handwritten note provided little clarity on the purpose of the meeting or its outcome. She said that statements from Mrs C or her son did not seem to have been obtained, although they were witnesses to the ambulance crew arriving at Mrs C's home; crew statements referred to in the Report were not made available; and findings made in the Report referred to the matter being progressed through 'an internal investigation the outcome of which will be decided by a Senior Manager', although there was no documentation relating to this. Overall, the Adviser was of the view that the Service completed a poor investigation, which did not provide detailed findings or reassurance (the Chief Executive's letter refers, see paragraph 9).

18. In accordance with our usual practice, a copy of the draft report on this complaint was issued to both Mrs C and the Service to give them an opportunity to comment on the factual accuracy of the text. It was at this stage that the Service advised that in response to Mrs C's complaint, a disciplinary hearing involving one of the members of staff concerned (the other staff member had left the service) had been held on 18 September 2012. The Board reported that findings were made and action was taken.

Conclusion

19. I have carefully considered all the information made available to me and I have accepted the Advice given. In light of this, I uphold the complaint. However, I am also concerned at the Service's response to Mrs C's written complaint to them, as this seems to be entirely inadequate and not proportionate to the seriousness of the allegation. There was no evidence

available to me that statements from any of those involved, including the ambulance crew, were obtained. None of those involved were given an opportunity to provide their own version of events. Had this been so, further insight into the situation may have been obtained.

20. I am also greatly concerned that not all the available information was provided to me when it was requested (see paragraphs 16 and 17) and was only produced at a very late stage in the investigation process (see paragraph 18). This does not instil confidence in the Service's internal procedures.

21. I, therefore, recommend that the Service make a formal apology to Mr and Mrs C for their failure to properly immobilise Mr C after the incident on 24 March 2012. Also, that they apologise for the inadequacies of their internal investigation.

22. Finally, the Service should externally audit their complaints handling processes to ensure that they are sufficiently robust and fit for purpose.

Recommendations

23. I recommend that the Service:	*Completion date*
(i) make a formal apology to Mr and Mrs C for their failure to properly immobilise Mr C after the incident on 24 March 2012 and for the inadequacies of their internal investigation; and	23 April 2014
(ii) externally audit their complaints handling processes to ensure that they are sufficiently robust and fit for purpose.	24 September 2014

24. 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
Mr C	the complainant's husband
the Service	the Scottish Ambulance Service
the Adviser	an experienced registered paramedic
the Manager	the General Manager of the East Central Area
the EPRF	Electronic Patient Report Form
the Guidelines	the Joint Royal Colleges Ambulance Liaison Committee, Neck and Back Trauma Guidelines, 2006
GCS	Glasgow Coma Score
the Report	the Service's Formal Complaint Investigation Report

Annex 2

Glossary of terms

Glasgow Coma Score (GCS)	the numeric value used in all clinical settings to establish the level of consciousness in a patient. A GCS of 15 indicates no impairment, and a GCS of 3 indicates a lack of consciousness
Paraplegia	complete paralysis of the lower half of the body including both legs, usually caused by damage to the spinal cord