SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Case ref: 202309999, Scottish Ambulance Service

Sector: Health

Subject: Ambulance / Failure to send ambulance / delay in sending ambulance

Summary

The complainant (C) complained to my office on behalf of their parent (B) about the response from the Scottish Ambulance Service (the SAS) to requests for an ambulance to attend B's spouse (A).

A was at home on 6 March 2023 when B and their neighbour (D) called the SAS. In total, three calls were made to the SAS to request an ambulance for A. An ambulance was dispatched in response to the third call; however, A died before its arrival. It was later confirmed that A had suffered a myocardial infarction (a heart attack, when blood flow to the heart is blocked).

C complained to me (having been through the SAS' complaints process) that the SAS had failed to reasonably respond to the calls made about A. In particular, that Call 1 was inappropriately triaged and there was a failure to re-triage A as an emergency after Call 2 clearly described a significant deterioration. C also complained that the SAS had failed to reasonably respond to their complaint.

In response to C's complaint the SAS advised that they prioritised the calls using the Medical Priority Dispatch System (MPDS, a computerised system in which a coded response level is determined in response to information provided by the caller). Based on the information input by the call handlers Calls 1 and 2 generated 'Teal' responses. Had it been apparent that A was in either cardiac or peri-arrest then call handlers would have documented this, asked further relevant questions and provided further pre-arrival advice and guidance.

During my investigation I took independent advice from a paramedic. Having considered and accepted the advice I received, I found that:

Call 1

Having listened to the call, I recognise and acknowledge the pressured environment SAS call handlers are in, and that they are required to follow a defined script. Nevertheless, a key symptom was missed, with the key word 'gasping' not being picked up. This led to a missed opportunity to identify A's ineffective breathing. Best practice would have been to have picked it up and acted at this point.

Call 2

The SAS did not correctly triage Call 2. Information shared about A's rasping breathing, blue lips, and temperature and clamminess were not acted on, and the call was not coded correctly. This was unreasonable. While it cannot be known what further information would have been provided to the questions that would have been asked if the call had been correctly coded, when cardinal symptoms are mentioned throughout a 999 call it is reasonable to assume that a high category of response would have been provided, which reflected the SAS' own findings when they audited the call.

Call 3

The SAS reasonably responded to Call 3.

Taking all of the above into account, I upheld C's complaint about call handling.

Complaint handling

When responding to the first complaint submitted by C, the SAS did not respond to all the key points made. This was unreasonable.

Given the basis of C's complaint was that A had died as a result of an incorrectly triaged call, it would have been reasonable to expect the calls to have been audited prior to responding to C's initial complaint.

When C reiterated their questions following receipt of the first complaint response, the SAS provided a more thorough answer. However, they did not disclose in their second response that they had carried out an audit of Call 2 which had identified there was a failing. This was unreasonable, lacked transparency and went against the principles of the duty of candour legislation and good complaint handling.

The SAS should have also considered undertaking a significant adverse event review (SAER). There is no evidence that one was considered which was unreasonable.

Taking all of the above into account, I upheld C's complaint about the SAS' handling of the complaint.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Scottish Ambulance Service to do for C:

Complaint point	What we found	What the organisation should do	What we need to see
(a) and (b)	I found that the Scottish Ambulance Service: • Missed an opportunity to identify a key symptom in Call 1 and did not reasonably respond to Call 2. • Failed to meet their duty of candour obligations when they identified the failings in	Provide an apology to C for the failings as identified in this report. Consult with C, and if they consider it would be beneficial to B, provide an apology to B for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.	A copy of the letter(s) of apology By: a month from the date of the final report.

Complaint point	What we found	What the organisation should do	What we need to see
	Call 2. • Did not reasonably respond to C's complaint. • Should have considered carrying out a SAER.		

We are asking the Scottish Ambulance Service to improve the way they do things:

Complaint point	What we found	Outcome needed	What we need to see
(a)	The Scottish Ambulance Service missed an opportunity to identify a key symptom in Call 1 and did not identify 'ineffective breathing' and appropriately code Call 2, impacting on the priority level of Call 2 and dispatch of an ambulance.	Call handlers should have sufficient knowledge to accurately identify and record cardinal symptoms during 999 calls.	Evidence training is provided to call handlers to ensure they can accurately identify critical symptoms during 999 calls. Evidence the Scottish Ambulance Service has reviewed whether further action / training is required if there are similar deficits in call handlers accurately identifying other cardinal symptoms. With details

Complaint point	What we found	Outcome needed	What we need to see
			provided of the decisions reached and any actions taken following this review. Evidence of a process to ensure that where learning for an individual on zero hours ‘bank’ contract is identified, and the bank worker seeks to carry out a shift, that this training is completed prior to the individual doing their next shift. By: two months from the date of the final report.

We are asking the Scottish Ambulance Service to **improve their complaints handling**:

Complaint point	What we found	Outcome needed	What we need to see
(b)	There were failings in the handling of C's complaint in that: • The Scottish Ambulance Service's investigation into the complaint did not fully address the concerns raised by C; • consideration should have been given to carrying out audits of the calls when responding to C's complaint given the basis of the complaint was that A died as a result of an incorrectly triaged call.	Complaints should be thoroughly investigated, with failings identified and action taken in light of this. Appropriate consideration should be given to carrying out audits of calls when responding to complaints.	Evidence that the outcome of the SPSO's investigation of the complaint has been shared with relevant staff. Evidence that the SAS have reviewed their criteria for auditing calls when investigating complaints to ensure they are sufficiently broad and effective, including whether, when a complaint is about a mis-triage of calls, and involves a death, the calls in question should be audited. Evidence to be provided of the review and action taken. Evidence that staff undertaking audits receive appropriate training. By: two months from the date of the final report.

Complaint point	What we found	Outcome needed	What we need to see
(b)	The Scottish Ambulance Service's investigation identified a failing (with Call 2) but did not share this with the complainant, leading to a poor response to the complaint and did not comply with their duty of candour obligations.	Where failings are identified, they should be acknowledged and apologised for by the Scottish Ambulance Service, with appropriate action taken in line with relevant legislation, policies and procedures (particularly duty of candour and adverse event policy)	Evidence that the outcome of the SPSO's investigation of the complaint has been shared with relevant staff. Evidence that staff investigating complaints receive appropriate training in complaint handling and duty of candour. Details of the SPSO's complaint handling training can be found at: Training courses | SPSO. From: two months from the date of the final report.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. C complained to me on behalf of their parent (B) about the Scottish Ambulance Service (SAS)' response to 999 calls made requesting an ambulance for B's spouse (A) on 6 March 2023. Three calls were made to the SAS to request an ambulance for A. An ambulance was dispatched in response to the third call; however A died before its arrival. It was later confirmed that A had suffered a myocardial infarction (a heart attack, when blood flow to the heart is blocked).

2. The complaint from C I have investigated is that:

(a) the Scottish Ambulance Service failed to reasonably respond to the calls made about A (*upheld*); and

(b) the Scottish Ambulance Service failed to reasonably respond to C's complaint (*upheld*).

Investigation

3. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation submitted to us by C and by the SAS, including call recordings and complaint correspondence. I also obtained independent advice from a paramedic (the Adviser).

4. In this case, I have decided to issue a public report on C's complaint to reflect my significant concerns about the failings identified in relation to the SAS' call handling and their investigation into, and response to, C's complaint. I also recognise the considerable personal injustice to C and B, and the potential for wider learning from the complaint, in particular in relation to complaint handling. This has informed my decision to issue a public report.

5. This report includes the information that is required for me to explain the reasons for my decision on this case. It also contains some technical medical terms and descriptions which I have considered necessary to include in order to provide the appropriate level of detail. Wherever possible, explanations for these terms are provided in the report.

6. While I have not included every detail of the information considered, my complaints reviewer and I have reviewed all of the information provided during the course of the investigation. C and the SAS were given an opportunity to comment on a draft of this report.

Key events

Time	Details of event
16:50	A and B's neighbour (D) call 999 (Call 1). Call Handler 1 asks if the patient is breathing. D confirms they are. Call Handler 1 asks if the patient is awake. D confirms they are awake. Call handler 1 confirms the address and asks what has happened. D states that A has lymphoma[1] and has woken up very confused. D passes the phone to B. B gives A's date of birth. Call handler 1 asks if A is breathing normally. B responds 'No (pause), no (pause), [A] is gasping air'. The underlined being said while Call Handler 1 moves on to the next question. B goes on to explain A has been experiencing pain, had cancer several years prior, and reports symptoms of confusion and sweating. Call Handler 1 states that a clinician will call back to give further advice and that if A gets worse to call back. C states that A has deteriorated in the last half hour and Call Handler 1 states again that someone will call back.
17:04	B makes another 999 call. Both B and D speak on the call (Call 2). When asked by Call Handler 2 if the patient is breathing, B states 'well barely, [A]'s rasping.' When asked if A is awake B states 'eyes are open but [A]'s not with us'. During the call B and D report that A has 'seesaw breathing', and that A's condition has worsened since the last call – paler, lips are blue, very cold and clammy. Call Handler 2 states that a clinical adviser is going to call back. B states that A's GP (the GP) said an ambulance is required and ends the call.
17:11	The GP calls 999 (Call 3). They report that B has told them A is cold and clammy with disordered breathing and not very rousable; and that blood test results returned from that morning were concerning for possible gastro-intestinal bleed. The GP requests an immediate response and states their view is that this is a life-threatening situation.

[1] It was later clarified by C that A did not have lymphoma during the complaint process.

Time	Details of event
17:16	Ambulance is dispatched
17:24	Ambulance arrives at the scene. On arrival it is reported that A had died and no resuscitation attempts had been made prior to the crew's arrival.

(a) The Scottish Ambulance Service failed to reasonably respond to the calls made about A

Concerns raised by C

7. C raised the following issues in their complaint:

i. Call 1 was inappropriately triaged.
ii. There was a failure to re-triage as an emergency after Call 2 clearly described a significant deterioration.
iii. There was a failure to provide advice on bystander cardiopulmonary resuscitation (CPR).

8. C was of the view that a more timely response could have saved A's life. They explained that the trauma of repeatedly trying to unsuccessfully raise the alarm has had a lasting and damaging effect on B's mental health.

The SAS' response to C's complaints

9. The SAS provided their first response to C on 6 November 2023. Key points from that response are:

i. The SAS use a system called Medical Priority Dispatch System (MPDS) to prioritise requests for emergency ambulances. This is a computerised system in which a coded response level is determined in response to information provided by the caller.

ii. The first two questions asked to everyone calling 999 are 'is the patient breathing?' and 'is the patient awake?'. This allows rapid identification of patients who are in an immediately life-threatening condition, and (if the answer to either question is 'no'), the system takes over the dispatch of the nearest available resource once the location is confirmed.

iii. If a patient is awake and breathing, and the location is confirmed, further questions are asked to determine the priority level of the call. Priority levels go from Purple (highest priority, primarily for patients in cardiac arrest), through Red, Amber, Yellow, Teal, to Lime.[2]

iv. Calls 1 and 2 made on behalf of A were triaged as 'Teal' calls and the information provided indicated that instead of an immediate ambulance being dispatched, a further clinical telephone triage by an Advanced Practitioner should be carried out.

v. Before the Advanced Practitioner could call back, a third call was received from the GP and was requested as an 'Immediately Life Threatening' (Red) call.

vi. The first available emergency ambulance was dispatched at 17:16, arriving at 17:24. En route to the address, a railway level crossing safety gates were down, and the crew had to take an alternative route to speed up arrival to the scene. When paramedics arrived, it was reported that A was already deceased, and no resuscitation attempts had been made.

10. C was dissatisfied with this response and the SAS provided a second response on 6 December 2023. Key points are as follows:

i. Both calls had been listened to and confirmed that the information given by B and D on the calls were that A was conscious and breathing, had lymphoma, and was confused. The SAS reiterated their position that the information provided indicated a further clinical triage by an Advanced Practitioner (a Teal response).

ii. The MPDS triage system is used by non-clinical call handlers who are speaking to non-clinical callers via the 999 system. MPDS establishes a universal standard for call handlers taking calls for a broad range of responses. MPDS is designed to ensure that emergency ambulances are available to attend the most serious and life-threatening cases in the first instance. It provides a triage tool to support non-clinical call handlers in the assessment, categorisation and provision of advice in relation to 999 calls.

iii. Based on the information provided, Calls 1 and 2 generated 'Teal' responses. Had it been apparent that A was in either cardiac or peri-

[2] Further information on the SAS response hierarchy is in Annex 2.

arrest then call handlers would have documented this, asked further relevant questions and provided further pre-arrival advice and guidance.

The SAS' response to SPSO

11. In response to a request from my office, the SAS provided information about audits carried out by the SAS on Calls 1 and 2. The audit of Call 2 had been carried out on 29 November 2023 as a result of C's second complaint; the audit of Call 1 was carried out in May 2024 as a result of contact from my office. The results of those audits were as follows:

i. Call 1 was considered to be highly compliant. It was noted Call Handler 1 was calm and polite and a sensible chief complaint was selected based on the information and the call was processed efficiently through the protocol.

ii. Call 2 was considered to be non-compliant. Call Handler 2 was correct in triaging the call as a new emergency call given the patient's condition had worsened. However, an incorrect answer was inputted for the response to 'is the patient breathing?'. From the information given on the call by the caller, 'ineffective breathing' should have been selected by the call handler, given the caller said the patient's lips were blue and they were rasping. As such, coding CC06 would have been more accurate to address the chief complaint of 'ineffective breathing / raspy breathing'. It was noted that this would have initiated an echo (Purple) coding with no further delay. It was recommended that the call handler undertakes further enhanced training on ineffective breathing.

12. The SAS told me, in a response dated 15 May 2024, that if the CC06 code had been applied to Call 2 it would have generated a Purple response, and that in 2023-24 the median response time target for a Purple call was seven minutes.

13. In response to my further enquiries, the SAS provided the following additional information:

i. The MPDS system is a scripted protocol whereby a call handler goes through an algorithm on the screen, asking the questions the system presents and entering the answers provided by the caller. The script must not be deviated from at any time and the call handlers have no autonomy. It is important to note that call handlers are not clinical.

ii. Call 1 was categorised as Teal which means that the call was referred to an in-house clinician in the Integrated Clinical Hub (ICH) for a more in-depth clinical triage. The ICH is there to provide clinical support in managing outstanding calls, and also to better understand more complex patient presentations that the MPDS system would not understand. This more in-depth clinical triage ensures that the patient is provided the right response; this might be that the call is upgraded to Amber or Red, there could be a referral made to another care pathway, or prescribers can arrange for prescriptions. Being referred to an ICH clinician does not mean that this is a low priority call; it is considered a call that may very well require a response, but there is more information required before the priority level is applied. Each caller is provided with instruction to call back on 999 if anything changes.

iii. It is not possible to say what a clinician in the ICH would have done had they been given the opportunity to call this patient back, as there is no way to know how that discussion would have progressed.

iv. During Call 2, Call Handler 2 correctly identified that A's condition had changed; however, an opportunity was missed, and instead of coding the call as '06' (breathing difficulties), Call handler 2 remained on code '26' (unwell person) which resulted in the priority being given again as Teal. The SAS said that it was not possible to determine what priority level would have been given had code '06' been explored and to do so would be purely speculation.

v. The SAS offered to apologise for the error made in coding Call 2.

vi. The SAS said that in the event Call 2 was graded as an emergency, it may have resulted in an ambulance being on the scene 8-10 minutes earlier if the crew were available at that time. However, it is not possible to say whether the outcome would have been any different. It is unclear exactly when the cardiac arrest happened, but it certainly would have happened prior to the crew arrival or just as they arrived. The SAS also said, any attempt at resuscitation would likely have been futile, as is evidenced by the joint decision making with the GP on the scene.

vii. Though they had previously stated that if Call 2 had been correctly coded this would have resulted in a Purple response and as confirmed by the findings of the audit of Call 2 (see paragraphs 11.i and 12), the SAS' position at this point was that it was speculative to attempt to determine what would have happened. They said that whilst an

ambulance would have been automatically dispatched if the call had been coded as 06, the questions would have continued, and the response could have been downgraded depending on the information given.

viii. Code 06 would not necessarily have resulted in CPR instructions being given. The initial information given was that A had ineffective breathing (rasping breathing) so CPR protocol would not have been triggered at that point. If information was provided by the caller indicating that A had stopped breathing, then CPR advice would have been provided to the caller.

ix. On the date in question, the SAS was on 'Call Escalation Plan Level 2'. This is used in situations of excessive call volume or reduced staffing and is a plan of mitigating actions to alleviate the pressure of increased demand. Level 2 of the Call Escalation Plan states that after giving any required post-dispatch instructions, call handlers will disconnect from unstable first- and second-party callers, excluding patients who require pre-arrival instructions, for example CPR or airway management. This means that unless the patient was in active cardiac arrest, the call would have been disconnected prior to the ambulance arriving.

Advice

14. The Adviser had access to the call recordings from Calls 1, 2 and 3, the audit results, the SAS' relevant policies and procedures; their responses to my office's enquiries as well as the SAS complaint records.

15. I have outlined the key points of the advice I received below.

Call 1

16. The Adviser noted the initial call at 16:51 was placed by B's neighbour (D) who initially reported that the patient was conscious and breathing. It was D who reported a background of lymphoma. The 999 call was then passed to B, who reported confusion and sweating. This led to the call handler triaging the call as a '26C01' MPDS code (sick person with an altered level of consciousness).

17. The pivotal piece of information missed by Call Handler 1 (and seemingly the reviewing team(s) at the SAS) takes place during Call 1 at 1 minute 28 seconds, where B is asked 'is the patient breathing normally?'. The response is 'no (pause), no (pause), [A] is gasping air'. This should have immediately led to further investigation of this cardinal 'ineffective breathing' symptom, redirection from the '26' chief

complaint stem and into ‘06’ (Breathing Problems). The call handler would then have been prompted to perform a breathing assessment but with the reported ‘gasping’ there is a very high likelihood that the call would have been classed as a Purple response. The unknown is the caller’s subsequent responses and whether these would have resulted in a reprioritisation, or the ambulance being stood down, but the initial information available would have resulted in a Purple or Red response due to the reported gasping alone. To this end, the handling of the call was unreasonable.

18. The fact the call was passed from D to B can be considered a limited mitigating factor for the error, as it made going through the protocol more difficult for Call Handler 1. Nevertheless, the Adviser’s view was that the response regarding breathing difficulties was very clear. The SAS’ audit found the call to be ‘highly compliant’ and did not mention this clear error.

19. The Adviser said that it is reasonable to consider that an ambulance would have been dispatched if Call 1 had been correctly coded.

Call 2

20. As acknowledged by the SAS in their audit of Call 2, Call Handler 2 missed key information of ‘rasping [breathing]’ and ‘blue lips’. The caller reported that A was not breathing normally, and was out of it, which should have led to a different triage pathway / chief complaint identification.

21. The response from the caller around abnormal breathing should have been investigated further but the reports detailed above would almost certainly have resulted in a Purple or Red response. The Adviser noted that despite some documents from the SAS claiming this could not be predicted, in the audit of Call 2 and the response of 15 May 2024 to SPSO, the SAS stated that it would have generated a Purple response.

22. Every call taker in an ambulance control room is provided with an internationally-standardised MPDS card set as a backup for the now digitised triage system which are accessible and clearly list chief complaints and follow up questions. Determinants for Purple coding within the 06 triage category are ‘ineffective breathing’ (06E01). Determinants for Red coding include ‘not alert’ (06D01), ‘difficulty speaking between breaths’ (06D02), ‘changing colour’ (06D03), clammy or cold sweats’ (06D04). It is absolutely clear that the family were reporting a number of these symptoms, and at a minimum a Red response would have been initiated. The claim that this cannot be known is only partly true: responses to later questions may not be fully predicted but when cardinal symptoms are mentioned throughout the 999

call, then it is reasonable to assume that a high category of response would have been provided.

23. The Adviser said that it is reasonable to consider that an ambulance would have been dispatched if either of the two initial calls (Calls 1 and 2) had been correctly coded.

24. Had the calls been triaged correctly, then pre-arrival instructions would potentially include counting of respiratory rate or providing CPR if / when the patient went into cardiac arrest.

25. The instructions given to a 'no send' triaged call (i.e. a call that does not result in ambulance dispatch) are to alert the caller to re-dial 999 if the patient's condition worsens. In Call 2, B ended the call before instructions were given so it cannot be determined whether they would have been provided or not. It appears that the family's response to being told the call would be passed to a clinician for a callback and an ambulance would not be dispatched, was to clear the call. Had the family been informed that an ambulance was being arranged they may not have cleared the line and pre-arrival instructions, potentially including CPR advice as may have been required, could have been provided.

26. As the call was triaged (albeit incorrectly) as low priority and B had been advised a clinician would call back, it was reasonable that Call Handler 2 did not attempt to return the call. However, had the call been triaged correctly, there would almost certainly have been an attempt made to recontact B and, depending on status, stay on the line until the ambulance arrived.

Call 3

27. The handling of this call was reasonable. An immediately life-threatening category was chosen by the call handler and responded to appropriately by the SAS. It was reasonable that CPR instructions were not given. There was no mention / indication that the patient was in cardiac arrest at this stage. The GP was remote from the patient but described the patient as conscious and breathing (based on the last time they spoke to the family).

28. In summary, the Adviser said that A and their family were failed by the service on two occasions during the initial 999 calls. Calls 1 and 2 were both inappropriately triaged and should have resulted in an ambulance response, which may have initiated treatment before cardiac arrest occurred. Additionally, had these calls been triaged correctly then B may have remained on the line (at which point CPR instructions could have been provided when / if necessary).

The SAS' comments on the draft report

29. As is my usual practice, a draft report of this decision was shared with both parties for their comments. No comments were received from C. I have included in this decision details of the responses from the SAS. I have included them and the ongoing exchange to reassure the SAS that their comments were carefully and appropriately considered.

30. The SAS provided the following comments in relation to complaint point (a).

Decision to issue a public report

31. The SAS flagged concerns about the apparent lack of clear governance surrounding the decision that the complaint warranted a public report. In particular, the concept that a step such as this relies on discretion rather than an agreed and documented governance, trigger points and/or measurement criteria.

Call 1

32. The service carried out a form of Bolam test[3] to listen to the call and none of the staff initially picked up on B saying that A is gasping air. It was only when they were asked to listen again and informed when it was stated in the call and the word to listen out for that the words were heard. The SAS had also commissioned an independent review of the call which did not pick up on B saying A was gasping air. The assertion that it was reasonable for Call Handler 1 to have picked it up in their one opportunity, in a live call environment, was challenged.

33. The script cannot be deviated from and the answer 'no' to 'is the patient breathing normally?' would never be explored further as it is not part of the script. Any answer to the question 'is the patient breathing normally?' will have no impact on the coding but subsequent question(s) are there to establish a possible cause for the reported symptoms (in the case of call 1, confusion).

34. The independent review did identify some minor concerns around customer service but ultimately the issues picked up would have made no difference to the response. The SAS provided my complaints reviewer with a copy of the independent review report which identified four recommendations.

[3] An assessment undertaken by similarly trained individuals to determine whether the actions of someone are in line with the actions of others in the same position.

Call 2

35. Call takers are not provided with an MPDS card set as back up, there is a collection of back up cards within the control centre that are available if the system goes down and can be handed out when required.

36. They considered the information provided in paragraph 22 was incorrect. They stated there are various priority codes under code 06.

Code	**Business as Usual Priority**	**Call Escalation Plan 2 Priority**
06E01	Purple	Purple
06D01	Red	Red
06D02	Amber	Amber
06D03	Amber	Amber
06D04	Green	Green

37. Given the various priorities under code 06, with green indicating no immediate dispatch, there is no substantive evidence that there would be an ambulance dispatched or that pre-arrival instructions would have been given had the call been correctly coded.

38. Inclusion of information provided by a member of staff when the primary liaison was absent (referenced at paragraph 12 and the decision) is challenged, as the comments were picked up on as not entirely accurate on the primary liaison's return[4].

39. There is no guarantee that CPR instructions would have been given.

Further advice from the Adviser

40. In response to the SAS' comments on the draft report of this decision, I obtained further advice.

Call 1

41. Call 1 had been listened to in a quiet room and 'gasping' was picked up on the first listen. The answer 'no', to 'is the patient breathing normally?', in itself would not

[4] The comments at paragraph 12 were provided by a member of SAS staff when the SAS primary liaison contact for SPSO was unavailable.

have changed the chief complaint, but ‘gasping’ would have. ‘Gasping’ was considered audible on one listen. The call handler was speaking over the caller at the time which is a mitigating factor.

42. If it is accepted that it was reasonable to have missed the ‘gasping’ information, the SAS’ position that the call had been correctly triaged is reasonable and the answer ‘no’ would not have led Caller 1 deviating from the code 26 script.

43. There are various priority levels under chief complaint 06. Given the level of information available in Call 1, it is not possible to predict which sub-category would have been appropriate if ‘gasping’ had been identified in Call 1.

Call 2

44. It is accepted that MPDS card sets are available for when the system goes down, the comments were made to challenge the SAS’ position that it was impossible to determine an outcome, as the card sets are there and can be used to determine the questions that would have been asked to some degree, taking into account that the responses could not always be predicted, but some of the information was volunteered by the caller without prompt.

45. Although MPDS is an internationally standardised system of triage, each individual service response may vary and it appeared that the SAS had changed their response to triage categories. Nevertheless, the Adviser considered there was still sufficient evidence that the conclusions remained the same. While accepting that there are various priority levels under chief complaint 06, given the responses to the initial questions, ‘is the patient breathing?’ (‘well no, rasping’) and ‘is the patient awake?’ ([A] is not with us, no’), the clinical response model would determine an immediately life-threatening condition. Even if mitigating that the answer to ‘is the patient breathing’ was not an absolute ‘no’, the answer to the next question was that A was unconscious. This should have resulted in the chief complaint being selected as ‘unconscious’ and the code 31 protocol as a minimum.

46. While acknowledging that it cannot be known what D and B’s responses to the never-asked questions would have been, given the severity of symptoms described further in the call (difficulty speaking between breaths, not alert, changing colour), within the 06 chief complaint, it was more likely than not that as an absolute minimum an ambulance would have been dispatched.

(a) Decision

47. The basis upon which I make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances, and in light of the information available to those involved at the time.

48. The SAS have challenged the decision to take the complaint to public report. Given the significant concerns about the call handling and complaints handling, I deemed it appropriate to publicly report and did so in line with SPSO's established procedures. Ultimately, as Ombudsman, my legislation gives me this discretion.

49. In investigating this complaint, I have obtained professional advice from the Adviser, as outlined above. I have carefully considered the advice alongside the information provided by C and the SAS in order to come to a decision. In doing so, I recognise that this has been and continues to be the most difficult of times for C, B and their family. They have my utmost sympathy. I also recognise that these events will have been difficult for the SAS staff, and in reaching my decisions I have taken into account, that because of the pressures on the service, the SAS were at Call Escalation Plan Level 2 when the events occurred.

50. Having listened to Call 1, I recognise and acknowledge the pressured environment SAS call handlers are in, and that they are required to follow a defined script. The advice I have received and which I accept is that there was a missed opportunity with the response to Call 1. The advice I have also received and which I accept is that being informed 'no' for 'is the patient breathing normally?', would not have triggered a different chief complaint, and therefore ambulance response. Accepting this advice, nevertheless, a key symptom was missed during the call, with the key word 'gasping' not being picked up. This led to a missed opportunity to identify A's ineffective breathing. Best practice would have been to have picked it up and acted at this point.

51. I further accept the advice that the SAS did not correctly triage Call 2. Information shared about A's rasping breathing, blue lips, temperature and clamminess were not acted on, and the call was not coded correctly. This was unreasonable.

52. The SAS did not identify any error in the handling of Call 2 when responding to C's complaint (I have considered the SAS' responses to C's complaint under complaint head (b)). Further to this, in response to my enquiries the SAS provided details of audits carried out which identified failings in the handling of Call 2. They initially indicated to my office, that had the correct code been applied to Call 2, it would have generated a Purple response, and that in 2023-24 the median response

time target for a Purple call was seven minutes (referenced from paragraph 12 above).

53. I note the SAS' statement in paragraph 38 above, that these comments were identified by SAS on the primary liaison officer's return as being not entirely accurate. However, the comments in paragraph 12 were reflected in the outcome of their own internal audit. In a later response, the SAS have indicated that it cannot definitively be stated exactly what would have happened had the call been coded correctly.

54. Nevertheless, the advice I have received and which I accept is that Call 2 was incorrectly coded and that, given the severity of symptoms described further in the call (difficulty speaking between breaths, not alert, changing colour), within the 06 chief complaint, it is more likely than not that an ambulance would have been dispatched.

55. In addition, the advice I have received is that when cardinal symptoms are mentioned throughout a 999 call it is reasonable to assume that a high category of response would have been provided and I note this is also borne out in the findings of the audit of Call 2.

56. Based on the evidence and advice received, contrary to the SAS' position, I consider the possibility of an ambulance being stood down or not dispatched at all, in these circumstances, as unlikely.

57. C is also concerned that there was a failure to provide instructions on bystander CPR. I accept the advice that, had Call 2 been correctly coded and an ambulance dispatched, there may have been an opportunity for CPR advice being given if the call was active when A went into cardiac arrest. The SAS were on Call Escalation Plan Level 2 on the date in question, so call handlers were disconnecting from calls after dispatch unless pre-arrival instructions were required. As it is unclear at what point A went into cardiac arrest, it is not possible to say whether the call would have been active at this point. Nevertheless, it is important to highlight that, it is possible there would have been an opportunity to provide advice on bystander CPR.

58. Overall, I consider the SAS missed an opportunity to identify a key symptom in Call 1 and failed to reasonably respond to Call 2, and I therefore **uphold** this element of the complaint. You will find my recommendations for the SAS at the end of this decision.

(b) The Scottish Ambulance Service failed to reasonably respond to C's complaint

Concerns raised by C

59. C raised the following concerns with my office:

i. that complaint response 1 did not answer the specific concerns raised.
ii. that complaint response 2 continued to provide an unsatisfactory explanation.
iii. that both responses provided no explanation of what criteria were met which led to an urgent call being downgraded to Teal for both Calls 1 and 2.

The SAS' response to SPSO

60. The main points of the SAS' response to my enquiries were:

i. The SAS apologised for not addressing the specific questions posed by C explicitly and recognised this likely caused unnecessary distress for the complainant.

ii. The service has limited resource to carry out formal audits of calls and cannot audit calls relating to every complaint. Therefore, complaints are reviewed initially by a management team, and if they have significant concerns around a call handling issue they will ask for a formal audit. At the time of the initial complaint, it was not identified that there were any significant deviations or errors within the calls, but when C submitted their further complaint, the investigating manager requested formal audits.

iii. The SAS acknowledged that in the second complaint response, they failed to make the family aware that there was an error picked up in the audit of Call 2. The investigating manager did not consider the error to be relevant to the questions asked, but in the future will ensure all evidence is disclosed.

iv. The SAS considered the level of review that was carried out was appropriate. The learning point was for Call Handler 2 to carry out learning in relation to identifying breathing difficulties. The call hander had left the service prior to the audits being carried out, and whilst they had a zero hours 'bank' contract, they had not done any shifts on this basis.

v. The SAS did not consider that the case would be a candidate for a Significant Adverse Event Review (SAER), because they were aware of the cause of the error and had taken steps to mitigate the risk of this happening again. They said that this, along with the fact it was not possible to know whether a response would have been quicker and their view it is unlikely the outcome would have been any different, would result in the case likely not being commissioned as a SAER.

Relevant legislation

61. The organisational Duty of Candour[5] is a statutory process. The obligations associated with the statutory duty of candour in Scotland are set out in the Health (Tobacco; Nicotine etc and Care) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018. The legislation states that organisations must take certain steps as soon as they become aware that an unintended or unexpected incident occurred in the provision of the service provided by the organisation, and that this incident appears to have resulted in or could have resulted in a number of outcomes, including death.

62. The intention of the Duty of Candour legislation is to ensure that providers of health and care services are open and transparent with people who use their services.

Advice

63. I asked the Adviser whether the action taken by the SAS in response to the complaint was reasonable. The Adviser considered that in relation to the identified failing in Call 2, ensuring Call Handler 2 had training to develop a broader understanding of categorising ineffective breathing was reasonable. However, they noted that the training had not taken place, and while the call handler was not working contracted hours, they still had a bank contract and could work shifts. The Adviser considered further action, in terms of a formal process to ensure the training occurs if Call Handler 2 started taking shifts again, should have been in place.

64. As it was identified during the investigation that it was not just Call Handler 2 that failed to identify ineffective breathing, but also Call Handler 1, the Adviser was of the view that wider action should be taken to ensure the understanding of categorising ineffective breathing.

65. In relation to the audits carried out by the SAS in response to the complaints, the Adviser said that the SAS consistently failed to identify the failings in Call 1 and

[5] Organisational duty of candour: guidance - gov.scot

reported it on numerous occasions as highly compliant. The Adviser noted that the calls were not audited until after C's second contact disputing the first complaint response and said they would have expected an audit of the calls to have been undertaken immediately given the basis of the complaint was that A had died.

66. The Adviser noted that both responses to C said that they had 'investigated the matter fully' but there were elements of C's complaint which were not addressed. The Adviser said it was unreasonable that after the failing of the handling of Call 2 was identified this was not disclosed to C or apologised for.

67. I also asked the Adviser to comment as to whether, in their view, the organisational Duty of Candour was relevant, and whether a SAER should have been carried out. The Adviser said that at the point the audit of Call 2 was conducted, the duty of candour policy should have been triggered. The Adviser also considered that the events would fall under the SAS' SAER policy and the adverse event should have been identified at the point the audit of Call 2 was carried out.

The SAS' comments on the draft report

68. In line with our normal practice, a draft report of this decision was shared with both parties for their comments, with the SAS providing the following comments in relation to complaint point (b).

69. It is unreasonable to expect a bank worker to be called in outside their available working hours and therefore learning and support must wait until they return to work.

70. The adviser's expectation that an audit would have taken place given the basis of the complaint was that A had died was a flawed assumption. The decision making relating to commissioning this type of review is complex and requires close monitoring for all staff. By the nature of an Emergency Service, cessation of life is a normal feature of the service and this, in itself is not a trigger for audit as it depends on the circumstances around the event.

71. While noting that the reference to Duty of Candour relates to Scottish legislation, the interpretation of how this is applied appears to be more around the England and Wales legislation. It remains the opinion of the service that this incident would not be a trigger for Duty of Candour under the Scottish legislation.

72. The service remains in a position where it is regretful in how this complaint was handled. The SAS are prepared to write or even meet C to apologise for the failure to address the complaint fully in the first instance and answer all questions they have. The SAS will seek to improve complaints handling which will include formalising heads of complaint at the beginning of any complaint to provide clarity for the

investigating officer and assurance for the complainant that questions will be answered where possible and, where necessary, explain reasons why certain questions may not be able to be answered.

73. The service acknowledges that the error identified in Call 2 should have been presented as part of the second response and apologise for this not happening.

74. It is not credible or reasonable to infer that the SAS was in any way attempting to hide information. The Service prides itself on its openness and honesty and stands by its long history of openly admitting and learning from its mistakes.

75. Given the comments provided in relation to complaint (a), it is unclear why the Ombudsman feels it is unreasonable that the SAS failed to identify any failings in Call 1.

76. There is no statement in the complaint responses that 'Call 2 was handled correctly' as originally referenced in the initial draft report.

Further advice from the Adviser

77. In response to the SAS' comments on the draft report of this decision, I obtained further advice to ensure that the SAS' comments were fully considered and taken into account.

Audit

78. The original advice provided was not meant to imply that every death should be investigated, appreciating that staffing levels may dictate that not all calls are audited. It would have been reasonable for an audit to have been triggered in the situation where a complaint has been received, a death is involved, and the complaint relates to an alleged mis-triage of a call. The results of such an audit should be shared openly with the complainant.

(b) Decision

79. I have considered the SAS' handling of C's complaints carefully together with the advice I have received, which I accept.

80. C's primary concern was that the complaint responses did not fully address the concerns they raised. In their first complaint, C had highlighted six questions which they wished the SAS to answer. The SAS did not fully respond to these questions in their first response, and I consider this to be unreasonable. I accept that the complaint process is not of itself a mechanism for every question a complainant may ask, to be answered. However, in this case the questions are clear and integral to the

complaint. If the SAS were unsure, the complaint handling process allows for them to contact the complainant to seek further clarification, which they did not do.

81. I welcome that when responding to me the SAS have apologised for not addressing C's questions in their first complaint response. Nonetheless, C is due a direct apology from the SAS, and it is positive that the SAS have confirmed their agreement to do so. I also consider there is learning for the SAS in relation to how they respond to complaints in future, which I have addressed when making my recommendations.

82. Turning to the call audits, it is for the SAS to determine what level of investigation is required to respond to complaints made to them, and I acknowledge the resourcing difficulties in auditing every call subject to a complaint. Having said that, given the basis of the complaint was that A died as a result of an incorrectly triaged call, I agree with the Adviser that it would have been reasonable to expect the calls to have been audited in order to respond to C's initial complaint. As this did not occur, I consider this to be unreasonable.

83. When C reiterated their questions following the first complaint response, the SAS provided a more thorough answer. However, they did not disclose in their second response that they had carried out an audit of Call 2 which had identified there was a failing. The SAS told me this was because the investigating manager did not consider the failing to be relevant to the questions being asked. Given the questions centred around the delay in ambulance dispatch, and the audit identified an incorrect coding, which had it not occurred would have resulted in an ambulance being dispatched, I consider this to be highly relevant to the complaint. It is unreasonable that the SAS did not include the information about the findings from the audit in their complaint response or apologise for the same.

84. It is noted that in the SAS' second response to the complaint they explained how the information from Call 2 triggered a Teal response, suggesting that this was appropriate, when the SAS were aware that this was not the case, based on the outcome of their internal audit of Call 2. This lacks transparency and goes against the principles of the Duty of Candour legislation – and good complaint handling. While I welcome that in response to my enquiries the SAS have said in the future they will ensure that all the relevant evidence is disclosed, I am conscious that my investigation report is the first time that C and B have learnt of these failings. This is unreasonable.

85. C has explained that the trauma of repeatedly trying to unsuccessfully raise the alarm has had a lasting and damaging effect on B's mental health. I am in little doubt that learning for the first time through reading my report that the SAS have been

aware since C made their complaint that Call 2 was non-compliant, but did not disclose this to C when responding, will only add to their distress. This could have been avoided had the SAS disclosed this information, as they should have done, at the outset.

86. I also accept the advice that after identifying the failing in Call 2, the duty of candour policy should have been triggered. I consider this would have been in line with Scottish legislation. The focus of the Duty of Candour legislation is to ensure that organisations tell those affected that an unintended or unexpected incident has occurred; apologise; involve them in meetings about the incident; review what happened with a view to identifying areas for improvement; and learn (taking account of the views of relevant persons). In addition, the SAS should have also considered undertaking a SAER. From the evidence I have seen these events appear to fall under the SAS' SAER policy but there is no evidence that one was considered. Again, I regard the failure to consider doing so to be unreasonable.

87. Given all of the above, I **uphold** this element of the complaint.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Scottish Ambulance Service to do for C:

Complaint point	What we found	What the organisation should do	What we need to see
(a) and (b)	I found that the Scottish Ambulance Service: • Missed an opportunity to identify a key symptom in Call 1 and did not reasonably respond to Call 2. • Failed to meet their duty of candour obligations when they identified the failings in	Provide an apology to C for the failings as identified in this report. Consult with C, and if they consider it would be beneficial to B, provide an apology to B for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.	A copy of the letter(s) of apology By: a month from the date of the final report.

Complaint point	What we found	What the organisation should do	What we need to see
	Call 2. • Did not reasonably respond to C's complaint. • Should have considered carrying out a SAER.		

We are asking the Scottish Ambulance Service to improve the way they do things:

Complaint point	What we found	Outcome needed	What we need to see
(a)	The Scottish Ambulance Service missed an opportunity to identify a key symptom in Call 1 and did not identify 'ineffective breathing' and appropriately code Call 2, impacting on the priority level of Call 2 and dispatch of an ambulance.	Call handlers should have sufficient knowledge to accurately identify and record cardinal symptoms during 999 calls.	Evidence training is provided to call handlers to ensure they can accurately identify critical symptoms during 999 calls. Evidence the Scottish Ambulance Service has reviewed whether further action / training is required if there are similar deficits in call handlers accurately identifying other cardinal symptoms. With details

Complaint point	What we found	Outcome needed	What we need to see
			provided of the decisions reached and any actions taken following this review. Evidence of a process to ensure that where learning for an individual on zero hours ‘bank’ contract is identified, and the bank worker seeks to carry out a shift, that this training is completed prior to the individual doing their next shift. By: two months from the date of the final report.

We are asking the Scottish Ambulance Service to **improve their complaints handling**:

Complaint point	What we found	Outcome needed	What we need to see
(b)	There were failings in the handling of C's complaint in that: • The Scottish Ambulance Service's investigation into the complaint did not fully address the concerns raised by C; • consideration should have been given to carrying out audits of the calls when responding to C's complaint given the basis of the complaint was that A died as a result of an incorrectly triaged call.	Complaints should be thoroughly investigated, with failings identified and action taken in light of this. Appropriate consideration should be given to carrying out audits of calls when responding to complaints.	Evidence that the outcome of the SPSO's investigation of the complaint has been shared with relevant staff. Evidence that the SAS have reviewed their criteria for auditing calls when investigating complaints to ensure they are sufficiently broad and effective, including whether, when a complaint is about a mis-triage of calls, and involves a death, the calls in question should be audited. Evidence to be provided of the review and action taken. Evidence that staff undertaking audits receive appropriate training. By: two months from the date of the final report.

Complaint point	What we found	Outcome needed	What we need to see
(b)	The Scottish Ambulance Service's investigation identified a failing (with Call 2) but did not share this with the complainant, leading to a poor response to the complaint and did not comply with their duty of candour obligations.	Where failings are identified, they should be acknowledged and apologised for by the Scottish Ambulance Service, with appropriate action taken in line with relevant legislation, policies and procedures (particularly duty of candour and adverse event policy).	Evidence that the outcome of the SPSO's investigation of the complaint has been shared with relevant staff. Evidence that staff investigating complaints receive appropriate training in complaint handling and duty of candour. Details of the SPSO's complaint handling training can be found at: Training courses | SPSO. From: two months from the date of the final report.

Terms used in the report **Annex 1**

A	The aggrieved, B's spouse
The Adviser	A paramedic providing independent advice on the case
B	The complainant's parent, A's spouse
C	The complainant, B's adult child
Call Escalation Plan	A plan of mitigating actions to alleviate the pressure of increased demand
CPR	Cardiopulmonary resuscitation, chest compressions given to a person in cardiac arrest to keep them alive
D	A and B's neighbour
ICH	Integrated Clinical Hub, where a more in-depth clinical triage is provided
MPDS	Medical Priority Dispatch System, a computerised system in which a coded response level is determined in response to information provided by the caller. More information can be found in Annex 2

Information on the SAS call prioritisation **Annex 2**

The Scottish Ambulance Service implemented the Clinical Response Model (CRM) for Emergency 999 calls in November 2016. The CRM aims to save more lives by more accurately identifying patients with immediately life-threatening conditions, such as cardiac arrest; and to safely and more effectively send the right type of resource first time to all patients based on their clinical need.

The model institutes a colour-coded system, which categorises 999 calls in terms of clinical need. Cases are coded purple, red, amber, yellow, lime and green.

In less urgent cases, call handlers may spend more time with patients to better understand their health needs and ensure they send the most appropriate resource for their condition and clinical need.

The process is also designed to identify instances when an ambulance is not needed and instead the patient can be referred to an alternative pathway such as GPs, NHS24 or outpatient services. All calls are triaged into the following categories:

Purple: The highest response priority, with a cardiac arrest rate over 10%, to respond with the closest resource, with paramedic attendance essential.

Red: The second highest response priority, with a cardiac arrest rate more than 1% and defined need for resuscitation. To respond with the closest resource and paramedic attendance essential.

Amber: The third response category, with less than 1% cardiac arrest rate. For calls with a defined need for acute pathway care, paramedic attendance preferred.

Yellow: The fourth response category, with less than 1% cardiac arrest rate and no defined acute pathway care.

Lime: the response for patients who are referred to NHS24 or signposted to the patient's own GP for further clinical assessment.

Green: For non-emergency incidents booked by a healthcare professional for a response in 1, 2, or 4 hours and to be taken to hospital. These patients have no emergency requirement and may be attended by a clinical or non-clinical crew for transport to hospital.

Teal: as referred to in this report, Teal is not a clinical acuity or a response category but instead is the ability to shield a particular code from a dispatcher and instead pass for a clinical assessment. Teal calls can be any colour, but primarily originate from the Yellow and Amber response categories.