Scottish Parliament Region: Lothian

Case 200401855: Scottish Ambulance Service Health Board

Introduction

1. On 25 June 2005, the Ombudsman received a complaint from a man (referred to in this report as Mr C) that, while his wife (Mrs C) was being placed in an ambulance, the crew (Crew 1) dropped her and that she suffered a type of seizure from which she never recovered and died a short time later. Mr C also complained that, apart from calling for a paramedic crew (Crew 2), Crew 1 did nothing to assist his wife.

2. Mrs C was a 54 year old lady who was disabled and had been treated for a brain tumour. She required to be taken from her home to hospital for a routine blood transfusion on 18 November 2004. A Patient Transport Vehicle (PTV) attended and Crew 1 moved Mrs C from her bedroom to the PTV using an ibex chair. It was while Mrs C was being transferred from the ibex chair to a seat on the PTV that she ended up on the floor of the vehicle. Crew 1 and Mr C managed to put Mrs C back in the seat and called for emergency assistance. Crew 2 arrived in an emergency ambulance a short time later and Mrs C was transferred to the ambulance, where she suffered a cardio-respiratory arrest (cessation of cardiac and respiratory function) en route to hospital. Mrs C was pronounced dead shortly after arrival at the hospital.

3. The complaints from Mr C which I have investigated were that:

(a) Crew 1 dropped Mrs C while transferring her from the ibex chair to a seat in the ambulance; and
(b) Crew 1 failed to provide appropriate treatment after Mrs C suffered the fall.

4. Following the investigation of all aspects of this complaint, I came to the following conclusions:

(a) not upheld, see paragraph 14;
(b) partially upheld, see paragraph 15.

Investigation and findings of fact

5. The investigation of this complaint involved obtaining and reading all the relevant documentation, clinical records, and complaint files. I obtained clinical advice from a medical adviser and an ambulance adviser to the Ombudsman. I also made written enquiries of Scottish Ambulance Service NHS Board (the Board). I have set out, for the two heads of Mr C's complaint, my findings of fact and conclusions. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. A list of abbreviations used in this report can be found at Annex 1. Mr C and the Board have been given an opportunity to comment on the draft of this report.

(a) Crew 1 dropped Mrs C while transferring her from the ibex chair to a seat in the ambulance; and (b) Crew 1 failed to provide appropriate treatment after Mrs C suffered the fall

6. Mr C first raised his concerns, in a letter to the Board dated 18 November 2004, that Mrs C was dropped when Crew 1 transferred her from the chair to a seat in the ambulance. As a result of the fall and by trying to pick her up, Mrs C suffered a seizure and died within the following hour. While Mrs C was suffering the seizure, Crew 1 made no attempt to assist her, apart from calling for an additional ambulance.

7. The Board investigation of the complaint included obtaining statements from Crew 1, Crew 2 and two patients who were already in the PTV when the incident occurred. The Chief Executive of the Board wrote to Mr C on 9 December 2004. He explained that the result of the investigation revealed that Mrs C was transferring across to the seat in the PTV from the ibex chair. She gripped the support rail fixed to the wall with her left hand and moved sideways across to the seat. However, her legs gave way and she appeared to faint, slipping to the floor. This could not have been prevented by Crew 1, who managed to assist Mrs C into the seat, where she seemed to recover although her complexion remained pale. Crew 1, who were a non-emergency crew, immediately called for an accident and emergency crew for assistance. In the interim, Crew 1 made Mrs C comfortable by placing a cushion at her head, opening her top collar and letting air into the vehicle by the side door. Crew 2 arrived within seven minutes to provide extended skills and transfer Mrs C to hospital for more definitive treatment. Crew 2 said that Mrs C was in respiratory and cardiac arrest before departing for hospital. In

summary, there had been no evidence that Crew 1 had 'dropped' Mrs C and paramedic assistance was summoned immediately, while Crew 1 made Mrs C as comfortable as they could. There was oxygen on board the PTV but this was not considered by Crew 1 as Mrs C appeared to be recovering and they could hear the emergency ambulance approaching.

8. Despite further local resolution, the matter could not be resolved to Mr C's satisfaction. He maintained that nobody had interviewed him or his neighbour, who had witnessed the incident, and that he interpreted the Board's responses as indicating that Mrs C's medical condition was somehow a contributory factor in the fall, which justified the crew's inability to handle the matter.

9. The Board re-investigated Mr C's complaint, which included a meeting with Crew 1 and a home visit to Mr C. The report findings were similar to the first investigation but had highlighted that patients in a non-emergency vehicle can suffer acute medical emergencies and that staff are not adequately trained or equipped to deal with them, other than call for emergency assistance. When Mr C received the report of the investigation, he wrote to the Board's Corporate Affairs Manager on 16 April 2005 and said that the Board had not taken his complaint seriously. His wife had been dropped by Crew 1 when she was being seated in the ambulance and ended up on the floor. He disputed that his wife had appeared to recover and stated that Crew 1 left the ambulance and did not return until Crew 2 arrived.

10. The medical adviser told me that the records indicated that when Crew 2 assessed Mrs C she had a respiratory rate of 10 and pulse of 58 (both slow) but a Glasgow Coma Scale (scoring system used to quantify level of consciousness) of 15 (normal conscious level) on arrival, which deteriorated on transfer to the emergency ambulance such that she stopped breathing. Her pulse remained at 50. Thereafter, she proceeded to full cardio-respiratory arrest. Initially her rhythm was EMD (electromechanical dissociation: a rhythm of the heart in which the heart continues to have electrical activity enabling the heart to beat but cannot produce an output or pulse) and later VF (ventricular fibrillation: a rhythm of the heart which is due to totally erratic electrical activity and produces no effective heart beat or pulse). This is compatible with massive pulmonary embolus (a clot to the lungs). It is compatible with the sequence of events following pulmonary

embolus. The death certificate confirmed that Mrs C died from pulmonary embolus secondary to deep vein thrombosis (clotting of blood in the leg veins). This is common in patients who have malignancy, particularly if immobile and certainly predated the ambulance journey. The terminal event could have happened at any time and could not in any way be attributable to the action of Crew 1. The adviser, however, had some concerns about Crew 1's actions following Mrs C's initial collapse and felt that it was likely she was in need of high concentration oxygen and close observation pending the arrival of Crew 2, although it would have made no difference to the final outcome.

11. I have seen statements from two other patients who were in the PTV when Mrs C suffered her initial collapse. They both said that Mrs C slipped to the floor while moving from the ibex chair to the seat.

12. In response to an enquiry from this office the Board explained that, although rare, serious medical events may occur while a patient under the care of Ambulance Care Assistants (ACAs) is en-route to an outpatient appointment. For that reason ACAs receive training in what to do should an emergency arise. This is covered in their basic training and is refreshed by post proficiency training each year. Crew 1, who were both ACAs, had already completed their post proficiency training for 2004/05. However, in view of the issues raised in Mr C's complaint, a training manager undertook a case review with Crew 1 so that they might benefit from lessons learned. The review included a full reconstruction of the event. Following Mrs C's collapse, Crew 1 very quickly called for emergency assistance. ACAs are trained to follow the 'SAFE' protocol = **S** - Shout for help; **A** - Assess the patient; **F -** Free from danger; **E -** Evaluate the dangers. If unconscious, keep safe until paramedic assistance arrives. The Training Manager considered that, apart from administering oxygen, Crew 1 could only but wait for emergency assistance since, prior to Crew 2's arrival, Mrs C was breathing and making verbal sounds. This was fully discussed with Crew 1, who had accepted they should have administered oxygen and would not fail to do so in future. In addition, all ACAs are regularly encouraged to administer oxygen for any patient who may present as pale or unwell and reminded of the potential benefits of doing so.

13. The medical adviser reviewed the response from the Board and noted that the standard training for ACAs covered basic first aid and life support. Such training

would be appropriate for these crews, who normally would not be involved in attending to cases of acute illness or injury. The adviser commented that the Board's instructions on administration of oxygen, while quite clear in specific circumstances, is less so in situations where a sudden emergency short of full cardiac arrest happens while the patient is in their care. The adviser noted the follow-up training and debriefing afforded to Crew 1 following the incident. In particular, she noted that the specific training concerning the use of oxygen in these situations and of base line observations would have reinforced the basic standard operating procedures and extended Crew 1's understanding, in relation to the rarer and more complex problems/occurrences patients may suffer whilst in their care. The adviser concluded that it seemed Crew 1 had acted within their level of training and expertise.

(a) Crew 1 dropped Mrs C while transferring her from a chair to a seat in the ambulance

Conclusions

14. Mr C believes that Crew 1 dropped Mrs C when they were moving her from the ibex chair to the seat in the ambulance. As a result of the fall, Mrs C suffered a seizure and died. Crew 1 maintain that Mrs C suffered a collapse while being moved and that she was not dropped. Two patients who were in the ambulance have said independently that Mrs C appeared to slip while she was being moved from the chair to the seat. What is not in dispute is that Mrs C ended up on the floor of the ambulance when she was moving from the chair to the seat. I have taken into account all the evidence obtained during the investigation and have concluded that there is no evidence that Crew 1 dropped Mrs C. I have also concluded that her fall to the floor was caused by a sudden collapse. The advice and explanations which I have received from the medical adviser is that Mrs C died from pulmonary embolus secondary to deep vein thrombosis. Such a cause of death is common in patients who have malignancy, particularly if immobile and certainly predated the ambulance journey. The terminal event could have happened at any time and could not in any way be attributable to the action of Crew 1. I accept in full the comments from the adviser and accordingly I do not uphold this aspect of the complaint.

(b) Crew 1 failed to provide appropriate treatment after Mrs C suffered the fall
Conclusions

15. Mr C believes that Crew 1 did nothing to assist Mrs C after her fall other than wait for the arrival of Crew 2. The Board maintain that Crew 1 made Mrs C comfortable after the fall and waited for the arrival of Crew 2, which would be in line with the level of training which they had received. However, ACAs are encouraged to give patients oxygen when there are concerns that they are unwell. It was accepted that Mrs C should have been given oxygen while waiting for Crew 2. The medical adviser has also said that, in her opinion, Mrs C should have been given oxygen, although it would not have made any difference to the final outcome. Taking all the evidence into account, I have decided to partially uphold the complaint to the extent that Crew 1 should have administered oxygen to Mrs C pending arrival of Crew 2. I have also taken into consideration the follow-up training and debriefing afforded to Crew 1 following the incident. Taking all this into consideration, the Ombudsman has no recommendation to make.

25 April 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
PTV	Patient Transport Vehicle: a non-emergency ambulance containing predominantly seating, usually used for the transporting of patients to clinics or hospital. Staffed by a non-emergency crew
Emergency Ambulance	999 Ambulance, used for transporting patients to hospital in an emergency and containing trolley beds. Staffed by ambulance paramedics and technicians
Ibex chair	A type of portable chair used when lifting or carrying people up or down stairs
Crew 1	The crew of the PTV who attended to Mrs C
Crew 2	The crew of the emergency ambulance who attended to Mrs C
ACAs	Ambulance Care Assistants, who receive training in basic first aid and life support
Paramedics and Ambulance Technicians	Ambulance staff, who receive extended training