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The investigation of a complaint against Welsh Ambulance Services University NHS Trust

A report by the
Public Services Ombudsman for Wales
Case: 202306104

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Introduction

This report is issued under s23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and other involved people have been changed. The report therefore refers to the complainant as Mrs A.

Summary

Mrs A complained about a lack of care and treatment by the Welsh Ambulance Services University NHS Trust ("the Trust") for her son, Mr B, on 14 December 2022. The Ombudsman's investigation considered the handling of 2x 999 calls, the standard of record keeping by the attending paramedic, and whether the earlier arrival of Trust staff would likely have affected Mr B's outcome.

The Ombudsman found a failure to properly manage the 2x 999 calls made in respect of Mr B. The First Call was incorrectly downgraded from "Red" priority to "Green 2". This meant a delay of 32 minutes in an ambulance attending Mr B. The Second Call was also not handled appropriately, with incorrect information given to Mrs A about cardio-pulmonary resuscitation. As a result, Mr B did not receive timely medical attention. Additionally, there was injustice to Mrs A and Mr B's brother, Mr C, as they spent 45 minutes attempting to deliver CPR to Mr B, without instruction or support.

In respect of the standard of record keeping by the attending paramedic, the Ombudsman found that fully accurate information was not entered on the patient clinical record particularly that the information was based on estimation. There was inconsistent reporting by the attending paramedic of what information was obtained from Mr B's family. This lack of clarity about the events of 14 December constituted an injustice to Mr B's family.

In terms of whether earlier attendance by Trust staff could have affected Mr B's outcome, the Ombudsman could not conclude with certainty that the earlier arrival of an ambulance would have made a difference. There was information that was not known, including the point at which Mr B suffered a cardiac arrest. As there was a small possibility of a different outcome for Mr B, this is an injustice to Mrs A and the family.

Whilst the Ombudsman's investigation did not set out to consider the Trust's handling of Mrs A's complaint, information came to light which highlighted concerns about the robustness of the Trust's investigation of the complaints it receives, particularly as this was not the only investigation she had seen which revealed deficiencies in the Trust's complaints

investigation process. Failures in the investigation process have meant Mrs A has unanswered questions about the care provided to Mr B which have left her with deep concerns.

The Ombudsman made a number of recommendations, which the Trust accepted. These included:

- An apology to Mrs A, an explanation about the shortfalls in the investigation process and payments totalling £2,750 for the distress and uncertainty caused and for Mrs A having to pursue her complaint.

- To review its approach to maintaining accurate clinical records to ensure it meets the requirements of The Health and Care Professions Council Standards of Practice.

- To remind all clinicians about the importance of good communication with those present at calls they attend.

- To share the report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future.

- To share the report with the Trust's Quality and Patient Safety Committee to consider the findings and include its learning from these recommendations in its Annual Duty of Candour report.

The Complaint

1. Mrs A complained about the care and treatment provided to her son, Mr B, by the Welsh Ambulance Services University NHS Trust ("The Trust") on 14 December 2022. The investigation considered:

a) The handling of 2x 999 calls made to the Trust in respect of Mr B.

b) The standard of record keeping demonstrated by the attending paramedic.

c) Whether the arrival of the Trust staff at an earlier point would likely have affected Mr B's outcome.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Trust and considered those in conjunction with the evidence provided by Mrs A. They also obtained clinical advice from 2 specialist advisers, Dr Les Ala, a consultant acute physician ("the Consultant Adviser") and Mrs Sue Pateman, an advanced paramedic and registered nurse ("the Paramedic Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Both Mrs A and the Trust were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidance

6. The Medical Priority Dispatch System ("the MPDS") is used by the Trust to dispatch the most appropriate medical resource to an incident. Emergency calls are answered by the Trust's emergency call handlers, who process calls using the MPDS. The software generates a questioning script based on the medical issue described by the caller and determines the most appropriate response based on the answers to these questions. A response code is then allocated to the call:

- Red, the highest priority response for immediately life-threatening situations (for example, respiratory or cardiac arrest).

- Amber 1, high clinical priority for potentially life-threatening emergency calls.

- Amber 2, for incidents considered serious but not immediately life-threatening.

- Green 2, for not clinically serious or life-threatening.

- Green 3, for calls deemed suitable for clinical telephone assessment.

7. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, often referred to as the Putting Things Right Regulations ("the PTR Regulations"), provides guidance to Health Boards and NHS Trusts on how to effectively handle concerns about NHS treatment and services.

8. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that "being open with service users and their representatives when things go wrong in their care is the right thing to do". This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes and specifically applies when a healthcare provider is responding to complaints about a service.

The background events

9. On 14 December **2022** Mr B, aged 35, was at home with his brother, Mr C, when he collapsed.

10. At 07:34 Mr C made a call to the Trust via 999 ("the First Call"). He explained to the emergency medical dispatcher ("the First EMD") that Mr B had been unwell the previous night with a cold or COVID-19 and had collapsed that morning. Mr C said he was unable to feel a pulse and did not think that Mr B was breathing. No instructions were provided to Mr C by the First EMD to perform cardiopulmonary resuscitation ("CPR" – an emergency lifesaving procedure performed when the heart stops beating).

11. At 07:35 a "Red" response (immediately life-threatening – the fastest response possible with an aim to respond within 8 minutes, using lights and sirens) was generated by the Trust. An emergency ambulance was allocated with an estimated time of arrival of 13 minutes.

12. At 07:40 it was noted that ProQA Paramount ("ProQA" – the Trust's emergency dispatch software programme) had failed to connect to its Computer Aided Dispatch system ("CAD").

13. At 07:40 the emergency ambulance was stood down after the call priority was downgraded to "Green 2" (not immediately serious or life-threatening with an aim to respond as soon as possible, without lights and sirens). This was as a result of an input code being manually entered by the First EMD into the CAD, which recorded that Mr B was obviously deceased.

14. At 08:11 Mrs A made a second call to the Trust via 999 ("the Second Call"). She explained that Mr B was unresponsive, but she was unaware if he was breathing.

15. At 08:12 the call was prioritised by the EMD ("the Second EMD") as "Red" and at 08:13 an advanced paramedic practitioner ("APP") and an emergency ambulance were allocated, with estimated times of arrival of 12 and 16 minutes respectively. Instructions were provided to Mrs A about performing 'mouth-to-mouth' resuscitation (blowing air into the mouth) on Mr B, but she was not instructed to do chest compressions.

16. At 08:14 the Second EMD was informed that there was black fluid coming from Mr B's mouth. At 08:15 another emergency ambulance was allocated with an estimated time of arrival of 12 minutes.

17. At 08:16 the Second EMD notified the APP that CPR was in progress.

18. At 08:20 the APP arrived at the scene, followed at 08:26 by the emergency ambulance staffed by 2 paramedics.

19. At 08:37 it was confirmed that Mr B had died. Following a postmortem examination, Mr B was found to have died from ketoacidosis, a condition where there is an overproduction of ketones (a type of chemical that the liver produces when it breaks down fats) that causes there to be too much acid in the blood.

Mrs A's evidence

20. Mrs A said that it took the Trust almost 45 minutes to attend to her son. She said this resulted in him not receiving timely treatment, which was vitally important, and could well have changed the outcome for him.

21. Mrs A said that there was no proof that Mr B suffered an immediate cardiac arrest (when the heart stops beating suddenly) at the point of his collapse.

22. Mrs A said that the information recorded on the electronic patient clinical record ("the ePCR") by the APP was fictitious. She said that the ePCR recorded that there had been a 10-minute delay in CPR being commenced, and that Mr B's collapse was not witnessed. However, Mrs A said that Mr C was metres away from Mr B when he collapsed, and Mr C immediately began CPR. She said that the APP was not there, she did not speak with Mr C to ascertain any details and therefore was unaware of the facts. Mrs A said that it was hugely upsetting that a professional person should manufacture details, when they should be reporting what was known as fact.

23. In respect of the communication with the APP, Mrs A reiterated that the APP failed to obtain any information about the events that had occurred prior to her arrival, recorded inaccurate information and demonstrated a complete

lack of basic kindness, which was inexcusable in the circumstances. Mrs A said that the APP failed to pass on information regarding the process and their options for seeing Mr B at the hospital. It was not made clear to them that they would not get the opportunity to see him again, as was the case.

24. Mrs A said that the Trust had been evasive in its dealings with her following Mr B's death. She said that she was not informed about any errors until March 2023, when she requested copies of the recordings of the 999 calls.

25. Mrs A said the information provided by the Trust about the member of staff who was sat with the First EMD during the call ("the Buddy") compounded the family's horror over the poor handling of the 999 calls. She questioned why an account of the events was not obtained from the Buddy at the time. Mrs A stated that the evidence of the Buddy was pertinent, and she is left questioning the authenticity of the Trust's investigation when the staff member was not approached in a timely manner to provide an account.

26. Mrs A questioned why, if the Buddy was experienced and available to assist the First EMD, they did not identify the errors made by the First EMD and intervene. She added that the Buddy would not have needed any additional training as a mentor to detect the errors made.

27. Mrs A said that the loss of her 35-year-old son, who had no significant health issues prior to his collapse, was completely devastating for the whole family.

The Trust's evidence

28. The Trust provided its condolences to Mrs A and her family.

29. The Trust confirmed that it undertook its own investigation into the circumstances surrounding Mr B's death. Its conclusions were communicated to Mr B's family and meetings subsequently took place with them. It said it made every effort to be open and transparent about these matters with Mr B's family.

30. The Trust said that sometimes the link between the CAD and ProQA will fail. When this happens, EMDs follow a 'fall-back process' which involves launching a standalone version of ProQA, not linked to the CAD, and the MPDS code being manually entered into the CAD.

31. The Trust said that its investigation found that the First Call was inappropriately prioritised as a "Green 2", instead of a "Red" response. It said that when the call was initially prioritised, it should have remained as a "Red" response and not been downgraded to a "Green 2" response.

32. As a result, there was a delayed response time of 32 minutes, along with a delay in providing CPR instructions. It said that if the call had remained "Red", an emergency ambulance could have arrived with Mr B within 13 minutes of the First Call being received.

33. In respect of the First EMD, the Trust clarified that they had commenced employment on 7 November 2022 and had undergone a full 3-week induction training programme. It confirmed that the First EMD had further completed approximately 3 weeks of employment during which they were taking 999 calls with supervision. The Trust said that they should have been provided with an appropriately trained mentor on 14 December 2022. Regrettably, due to staff sickness, the First EMD was placed with a member of staff who had not been suitably trained for mentorship, and who had not mentored previously ("the Buddy"). The decision by the supervisor was considered against the risk to waiting 999 calls as a result of the unprecedented service demand faced on that day.

34. In respect of the First Call, the Trust confirmed that the First EMD asked incorrect questions. It said Mr B should have remained as a "Red" priority, and CPR instructions should have been provided to Mr C to perform on his brother. It said that the First EMD failed to correctly assess the information given by Mr C that would have ensured that the call remained a "Red" priority and, had they fulfilled their duties appropriately, the information flow could have been more accurate.

35. The Trust said that it did not consider that chest compressions were carried out during the First Call. It said that it would have been obvious from the call recording if they had been, due to the physical exertion required to undertake them and that a steady rate of conversation would be unlikely to be maintained.

36. The Trust confirmed that the standard of the First Call was not the standard it expects from its call handlers. It assured Mrs A that the First EMD and the Buddy had received further formal training and support, particularly in relation to calls involving cardiac arrest.

37. In respect of the issue with the supervision of the First EMD, the Trust confirmed that it had implemented the following changes:

- Staff are now given more time on scenario work, including more complex scenarios, and knowledge checkers on these are completed.

- Department awareness sessions now include the Patient Safety Team (a team which plays a role in reviewing and learning from incidents to improve service provision).

- Ongoing work to develop the EMD training, and a 4-week induction course was piloted in March 2024.

- Staff are not only mentored by trained mentors, but also by buddies across all 3 sites to support the mentorship period.

- The Trust is seeking to increase the number of mentors as it has recognised that with high employee turnover and a lot of newer staff there are not enough mentors.

- The Trust has a specialist Learning & Development Team for emergency medical services coordination, and arrangements are being made so that this team is able to deliver mentorship training to staff. This training will be provided by the International Academies of Emergency Dispatch ("IAED").

38. In respect of the Second Call, the Trust said that this was also non-compliant, as incorrect information was provided to Mrs A about CPR. It said that during this call, Mrs A was asked to retrieve a defibrillator, but she responded that she felt it was too late. It confirmed as the call was a "Red" priority from the outset, the error in respect of CPR instructions did not cause a direct delay in getting help to Mr B.

39. The Trust added that ketoacidosis tends to produce deep fast breathing as a compensatory mechanism in the body to try and correct the increased level of blood acidity. This means that breathing was likely to be relatively easily detected, even if not appearing normal (it will often be fast, and with deep 'sighs'). It said the fact that during the First 999 call Mr C could not identify any sign of breathing was highly suggestive that these compensatory mechanisms were no longer working, and thus that cardiac arrest had occurred.

40. The Trust said that following its internal investigation and evidence presented for the Coroner's investigation, it did not consider that an ambulance arriving sooner would have changed the outcome for Mr B. This was because once Mr B had suffered a cardiac arrest, he would have had a low chance of survival.

41. The Trust said that it had shared Mr B's postmortem examination report with a consultant in anaesthesia and intensive care medicine. They said that virtually any cause of cardiac arrest would have a low chance of survival once cardiac arrest had actually occurred. It said that in Mr B's case, where the cardiac arrest was due to ketoacidosis, it would generally carry a very low survival chance. It said that the chance would be reduced further if CPR was not commenced immediately. It said that in this instance, the slim chance that Mr B had of survival was reduced to zero, due to the failure to perform CPR due to the coding issue.

42. The Trust said that Mr B's BMI (body mass index – a value derived from the mass and height of a person) indicated that he was underweight.

43. The Trust said that an internal incident report was submitted following Mr B's death and, as a result, an investigation was started. It said that the investigation was started prior to Mrs A raising a concern, and that the outcome of its investigation would have been shared with Mrs A, regardless of her submitting a complaint herself. The Trust did acknowledge that there was a missed opportunity to advise Mrs A that Mr B's case had been reported as a Nationally Reportable Incident ("NRI") to NHS Wales, and it apologised to her for this.

44. Mrs A raised concerns with the Trust on numerous occasions about its openness and transparency in its investigation process. In its response to Mrs A on 15 June 2023, the Trust confirmed that it had adhered to the Duty of Candour principles for many years, despite the legislation not being implemented in Wales until 1 April 2023.

45. In response to my investigation, the Trust confirmed that the initial "Red" priority assigned to the First Call was through the 'pre-alert' process. It explained that when an EMD answers a 999 call, and before processing a call using MPDS, the EMD asks 2 questions which are designed to identify the sickest patients and allow for the immediate dispatch of a resource to these patients: 'is the patient awake?' and 'is the patient breathing?'. This process is followed within the CAD system. These questions were asked in this instance, and it was identified that Mr B was not conscious or breathing. This triggered an initial "Red" priority. As the pre-alert process is an initial review, when an EMD has processed a call in full, the priority can change. This may be if later information indicates that a patient is in fact conscious and breathing, has regained consciousness, or if a patient is obviously beyond any help.

46. The Trust said that sometimes the link between the CAD and ProQA will fail. In these circumstances, the EMD can process the call using a version of ProQA which is not linked to the CAD. This does not impact the MPDS code that the EMD assigns but does impact how the EMD records the MPDS code within the CAD.

47. In this instance, the ProQA failure did not have any causal link with the incorrect MPDS code being assigned to the call. The reason that the call was not assigned the correct MPDS code was because the First EMD

recorded that Mr B was obviously deceased, which was not correct based on the responses to the questions asked. Given that Mr B was described to have just collapsed, there was no indication that resuscitation should not be attempted.

48. For absolute clarity, the Trust said that the 2 systems ("pre-alert" and ProQA) would have resulted in the same call grade had the First EMD not made an error.

49. The Trust informed my investigator that, soon after the incident, the Buddy changed roles. It confirmed that a statement was not obtained from the Buddy at the time, and due to the timeframe that has passed, they are unable to recall the incident.

50. The Trust also confirmed that staff working as buddies do not take their own calls and should either member of staff require a comfort break, no calls are taken during that time. The training received by the Buddy was the training provided to them as an EMD, with no additional training provided. The Buddy had experience of working as an EMD. The Trust confirmed that at the time of the First Call, the Buddy was plugged in to the call (a splitter cable was used to facilitate 2 headsets to a call) and listening at the time the call was taken by the First EMD.

51. The Trust said that the information recorded on the ePCR by the APP about the length of time CPR had been performed was an estimation. In respect of the completion of the ePCR by the APP, the Trust confirmed that it meets the requirements of The Health and Care Professions Council Standards of Practice ("HCPC").

52. The Trust said that when attending a cardiac arrest situation, all Trust staff are asked to undertake actions to support the chain of survival. It confirmed that across the ambulance sector, record-keeping takes place retrospectively rather than at the point of intervention and therefore all timings are estimated to a degree because of the nature of the care undertaken and the environment in which it is provided. It confirmed that it engages with other ambulance sectors across the 4 nations and shares learning and good practice. Any changes to its approach on completion of records would need to be considered as a wider sector to ensure consistency and the practical application of any changes.

53. It said that it did not agree that the APP did not speak with Mrs A or Mr C to obtain information. It provided a statement from the APP, dated 4 December 2023, in which she said, “I informed the family that the Police would be attending and explained the reason for this and spent some time with them in the middle downstairs room.” It said that staff members do not have access to the 999 calls, and only minimal information is shared prior to staff arriving at the scene. All other information recorded on the ePCR was the information supplied to, and observed by, the APP.

54. In a statement provided by the APP for HM Coroner, dated 24 August 2023, which was also supplied by the Trust, the APP did not reference a conversation with the family and stated, “I completed the paperwork, requested attendance of the police as per the ROLE policy. I cleared from the scene and continued with the rest of my shift.”

55. In its complaint response to Mrs A dated 30 October 2023, the Trust confirmed that it had returned to the APP regarding the rationale for entering 10 minutes into the ePCR. They advised the following, “To the best of my recall I believe that it was an estimated time, based upon the information given to me on the day of the time taken from the time of collapse to the patients brother finding [Mr B] on the floor, an assessment and then the movement from the bathroom into the box room where [Mr B] was located on my arrival”.

56. The Trust said during the First Call, which lasted 5 minutes, no CPR was ongoing. Therefore, following the conversation with Mr B’s family, an estimated time of 10 minutes (time to commencement of CPR by bystander) was recorded on the ePCR. This is supported by the First Call received at 07:34. The Trust acknowledged that 10 minutes was an estimated time. It said the medical record is a contemporaneous medical record and there is no requirement to indicate that a time is estimated. The Trust said that its staff are not trained to indicate when a time is estimated. It said on introducing the new ePCR, it liaised closely with other ambulance services within the UK and the requirement to indicate estimated records was not introduced.

57. The Trust confirmed that the inclusion of the word ‘estimated’ on the ePCR would not have changed its opinion about Mr B’s chances of survival.

The Call Recording

58. My Investigator listened to the recording of the First Call which is approximately 4 ½ minutes long. My Investigator noted that Mr C was not directly asked if he was performing CPR, and no instructions were given. They also noted that Mr C does not sound like he is administering mouth-to-mouth resuscitation, as that would likely have impacted on his ability to communicate effectively with the First EMD. The call recording does not confirm whether or not Mr C was carrying out chest compressions. Mr C indicated during the call that Mr B has “just kind of collapsed on the floor.” Mr C made no reference to the collapse having occurred 5 minutes before the First Call was made.

Professional Advice

The Consultant Adviser

59. The Consultant Adviser was asked to consider whether Mr B’s outcome would likely have been different had an ambulance arrived within 13 minutes of the First Call being made.

60. The Consultant Adviser noted that the postmortem examination of Mr B revealed the cause of his death to be ketoacidosis, but that there was no further explanation of the likely cause of this. Mr B was not known to suffer from diabetes, which is one potential cause of ketoacidosis.

61. The Consultant Adviser said that, noticeably, all other findings at postmortem examination were completely normal, and that otherwise, Mr B was a very healthy young man.

62. In respect of Mr B’s BMI, the Consultant Adviser said that whilst he was underweight, with a BMI of 15.5, postmortem examination did not show any cardiac features that you would expect to see in patients who are underweight (e.g. those with anorexia), such as reduced ventricular wall

thickness or reduced heart chamber volumes. The Consultant Adviser confirmed that patients who are underweight have a reduced chance of survival when suffering a cardio-respiratory arrest and confirmed that Mr B's low BMI would have reduced his chances of survival.

63. The Consultant Adviser noted that there was no definitive evidence of exactly when Mr B had suffered a cardiac arrest and said that this would not necessarily have happened at the time of Mr B's collapse.

64. In respect of the likely outcome being different, the Consultant Adviser said that had an ambulance not been delayed, the outcome potentially could have been different for Mr B, particularly in the absence of any other significant natural disease present at postmortem examination. However, he could not conclude with certainty that the outcome would have been different.

The Paramedic Adviser

65. The Paramedic Adviser was specifically asked whether it is clinically appropriate to record information in clinical records without any indication that the information is based on estimation rather than fact.

66. The Paramedic Adviser said that it is not acceptable to record estimated information in clinical records without indicating that it is an estimation. The HCPC Standards of Paramedics Proficiency (section 9 paragraph 9.1) states that paramedics must, "Maintain records appropriately and keep full, clear and accurate records in accordance with applicable legislation, protocols and guidance." The HCPC Standards of Conduct, Performance and Ethics (section 10 paragraph 10.1) states that paramedics must, "Keep records of your work and you must keep full, clear and accurate records for everyone you care for, treat or provide other services to."

67. The Paramedic Adviser confirmed that the HCPC Standards require records to be accurate, and therefore if a time elapsed has not been specifically recorded (such as could be found on a cardiac monitor), it would be a best guess estimate by the clinician, or a rough timing provided by those in attendance from the start of an incident.

68. The Paramedic Adviser said that the delay in starting CPR was not timed by the APP nor any bystander and is therefore unlikely to have been 10 minutes exactly. She added that it would appear from the Trust's investigation that a drop-down box has been used to enter the time before CPR commenced, which does not permit the inclusion of words such as approximate or estimate. She said this could have been recorded as an estimated time, and if there is no facility to put it in a specific field, it could be presented in the free text boxes which are available on ePCR forms. The Adviser reiterated that it is a requirement to distinguish between fact and estimate, and this did not happen in Mr B's case.

69. The Paramedic Adviser was also asked to consider the situation where a paramedic speaks with a person at a scene, whether they should record that the conversation has taken place and/or indicate the source of the information provided.

70. The Paramedic Adviser said that she could not identify any guidance which specifically requires a clinician to record who said what at the scene of any incident, although it would be good practice to do so. She confirmed that identifying where information came from helps with decision making, determining whether it is/was relevant and reliable and whether the information could be considered valuable if any follow up to a case was required. Recording who said what may also aid health care professionals' recollection of events at a later date.

Analysis and conclusions

71. In reaching my conclusions, I must consider whether there were failings on the part of the Trust and, if so, whether those failings caused an injustice to Mr B or his family. In doing so, I have considered whether the actions of the Trust met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

72. This report considers the care and service provided to Mr B by the Trust, and the likely impact of shortfalls in that care. My investigation has also considered whether anything could or should have been done differently to manage Mr B's wait for an ambulance.

73. I would like to extend my sincerest condolences to Mrs A and her family for the sad loss of Mr B.

Complaint (a)

74. The evidence I have received from Mrs A and the Trust confirms that the First Call made by Mr C on 14 December 2022 was not handled appropriately. The call was incorrectly downgraded from "Red" priority to "Green 2" by the First EMD, and no instructions were provided to Mr C in respect of carrying out CPR on Mr B. The downgrading of the call resulted in a delay of 32 minutes in an ambulance attending to Mr B. The Trust identified the incorrect prioritisation and the delay that caused in its response to Mrs A's complaint.

75. I note that the Trust informed Mrs A that the First EMD was not supervised by a suitably trained mentor. The Trust said that the First EMD was supervised by the Buddy, who was not suitably trained to mentor, and who had not mentored previously. The Trust did not inform Mrs A that the Buddy was a fully qualified EMD.

76. Whilst I note the Trust's comments about the Buddy not having received formal training to mentor the First EMD, I do consider that the First EMD would have had an expectation that the Buddy would have intervened in the event of them making an error. I do not consider that the Buddy, being a fully qualified EMD, required any additional training to undertake this task. No explanation has been provided by the Trust for the lack of intervention by the Buddy. The Trust did not obtain a statement from the Buddy immediately following the incident and no explanation has been provided by the Trust for its failure to do so. I consider this to be a failure in its investigation process and its subsequent handling of Mrs A's complaint. As a result, the opportunity to obtain key evidence has been lost and a full account of circumstances surrounding the First Call remains unknown. This is unsatisfactory for Mrs A who, despite investigations by the Trust and my office, still has unanswered questions about the events leading to the death of her son.

77. The Second Call made by Mrs A on 14 December was also not handled appropriately by the Second EMD, with incorrect information provided to Mrs A about CPR.

78. There is no evidence to suggest that any service failure was a result of the failure of the Trust's call handling software.

79. The Trust's failure to properly manage the 2x 999 calls made in respect of Mr B constitutes a service failure. As a consequence of the failure, Mr B did not receive timely medical attention following his collapse. Additionally, both Mr C and Mrs A were caused an injustice due to them spending a period of 45 minutes, where they were attempting to deliver CPR to Mr B, without instruction or support. This must have been incredibly distressing for them both. On this basis, I **uphold** this element of the complaint. As the Trust has already implemented changes to its induction programme (paragraph 36), I have not made any additional recommendations in this respect.

Complaint (b)

80. The evidence I have seen confirms that the ePCR completed by the APP documented that CPR was not commenced for 10 minutes following Mr B's collapse. There is no record that this time was an estimation. The advice I have received is that there was a requirement for the APP to distinguish between factual and estimated information on the ePCR. However, I note that the Trust's position is that in the context of emergency care in a community setting, record-keeping takes place retrospectively rather than at the point of intervention and that all timings are estimated to a degree.

81. I am concerned that there may be other instances involving other patients, for example the timing/administration of medication, when information contained on the ePCR will need to be accurate and not estimated. This could potentially lead to a situation where accuracy of information contained on the ePCR could be misinterpreted. Whilst I cannot adjudicate between the differing views of the Paramedic Adviser and the Trust, I do propose to recommend that the Trust takes appropriate steps to confirm that its approach meets the requirements of HCPC.

82. I have further noted that the statements provided by the APP do not provide consistent evidence about a conversation taking place with Mr B's family. There is no record on the ePCR that any conversation took place. I accept the advice received that it is considered good practice to record

the origin of information provided at the scene of an incident. Mrs A is clear in her evidence that the APP did not speak with her or Mr C to obtain additional information. Nor did the APP provide key information about the process following Mr B's death. I am persuaded by Mrs A's recollection of the incident, as I believe that Mrs A is more likely to have recalled the events in detail in view of the gravity of the situation and because the evidence of the APP has not been consistent. Additionally, the lack of information about the process resulted in Mrs A and her family being unable to see Mr B following his transfer to the hospital mortuary.

83. The failure to enter fully accurate information in the ePCR, particularly that the information was based on estimation, plus the inconsistent reporting by the APP of what information was obtained from the family, has meant a lack of clarity over events that morning. I **uphold** this complaint on that limited basis.

Complaint (c)

84. The Trust said that even if an ambulance had attended in a timely manner, they would have found Mr B in cardiac arrest, and his chance of survival would have remained extremely low. It subsequently said that any slim chance Mr B may have had was reduced to zero by the failure to perform CPR, due to the incorrect call coding.

85. The Trust said that the fact that during the First Call Mr C could not identify any sign of breathing is highly suggestive that cardiac arrest had occurred.

86. The evidence I have seen confirms that during the Second Call, Mrs A said she was unsure of the breathing status of Mr B. However, when advised to retrieve a defibrillator, Mrs B responded that she felt it was too late. There is insufficient evidence to say whether Mr B was in cardiac arrest at that time.

87. Mrs A said that CPR was commenced immediately by Mr C following Mr B's collapse. This was despite the failure of the First EMD to provide instructions. The Trust disputes this fact and said that the recording of the First Call did not evidence that Mr C was performing CPR at that time.

88. During the recording of the First Call, Mr C was not directly asked if he was performing CPR, and no instructions were given. I accept that Mr C does not sound like he is administering mouth-to-mouth resuscitation, as that would likely have impacted on his ability to communicate effectively with the First EMD. I do not consider that the call recording confirms whether or not Mr C was carrying out chest compressions. Mr C indicated during the call that Mr B had "just kind of collapsed on the floor." Mr C made no reference to the collapse having occurred 5 minutes before the First Call was made.

89. There is no definitive evidence to support exactly when cardiac arrest occurred, as there was no medical professional on the scene immediately following Mr B's collapse. There was uncertainty in the Second Call about Mr B's breathing status. I accept the Trust's evidence that once cardiac arrest occurs, chances of survival are low. However, we will never definitively know at what point Mr B suffered a cardiac arrest to be able to conclude, on the balance of probability, at what point his chances of survival decreased.

90. Mrs A said that CPR was commenced immediately. The Trust said that the recording of the First Call evidences that it was not. Given that we do not know at what point cardiac arrest occurred, I do not consider that we can conclude whether a delay of 4 ½ minutes (the duration of the First Call) was significant or not.

91. I fully accept that the possibility of a different outcome may have been remote for Mr B, and I also accept the advice received that we cannot say with certainty that earlier arrival of an ambulance would have changed the outcome. There is information that we simply do not know. On this basis, I consider there was still a possibility, however slim, that the outcome may have been different for Mr B had an ambulance arrived within 13 minutes of the First Call being made.

92. As the effect of the potential earlier arrival of the Trust staff on Mr B's outcome is not certain, this represents an enduring injustice to Mrs A and her family. Taking all of the above into consideration, I **uphold** this element of the complaint.

Complaint handling

93. Finally, whilst 'complaint handling' was not one of the heads of complaint I investigated, in light of the information that has become available during this process, I must address this. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. Whilst not in force at the time of the response to Mrs A, it was well known that the duty would be implemented, and in any event, the PTR Regulations under which the Trust responded to Mrs A's complaint places an obligation upon it to investigate concerns properly, efficiently and openly[1]. Additionally, in its complaint response to Mrs A, the Trust confirmed that it had followed the candour principles for many years.

94. I consider that the Trust's response to Mrs A fell well short of what the duty promotes and is intended to achieve. The opportunity to obtain key evidence has been lost and a full account of circumstances surrounding the First Call remains unknown. This is unsatisfactory for Mrs A who, despite investigations by the Trust and my office, still has unanswered questions about the events leading to the death of her son. That has left Mrs A with deep concerns about the care of her son at the end of his life.

95. In addition, and disappointingly, despite the Trust being asked to provide all relevant evidence to my office at the commencement of my investigation, it failed to do so. It provided one of the APP's statements 8 months after my investigation started and a key statement provided for the purposes of the Coroner's investigation was only provided in response to a draft copy of this report. In addition, no information was provided about the absence of key evidence from the Buddy.

96. This raises serious concerns about the robustness of the Trust's investigations of the complaints it receives. Concerningly, this is not the only evidence I have seen of deficiencies in the Trust's complaints investigation process. Alongside this report, I am publishing another public interest report[2] in respect of a different complaint received by my office, which highlights similar shortfalls in this respect. The Trust needs to ensure that in the future it responds openly and honestly to complaints, and that staff involved in

[1] As set out in Regulation 3 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 No. 704

[2] Case reference 202302966

formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so. My recommendations therefore take account of this failure.

97. I consider that I cannot adequately address the significant injustice caused to Mrs A and her family without recommending financial redress. I stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice caused as a consequence of the failings I have identified. I consider that the level of financial redress I am recommending appropriately reflects the distress caused to both Mrs A and Mr C during the prolonged time they were awaiting an ambulance and the subsequent uncertainty caused to Mrs A and her family.

Recommendations

98. I **recommend** that the Trust, within **1 month** of the date of this report:

a) Provides a meaningful written apology to Mrs A and her family for the failures identified in this report and acknowledge that it missed opportunities to provide timely care to Mr B. The apology should also include an explanation as to why the Trust's investigation did not appropriately consider the role of the Buddy in the handling of the First Call.

b) Offers Mrs A redress of £2,000 in recognition of the distress caused to both her and Mr C during the prolonged time they were awaiting an ambulance and the subsequent uncertainty caused to Mrs A and her family. To further offer Mrs A redress of £750 for the significant time and trouble she has been put to in pursuing this complaint to gain answers to her concerns.

c) Reviews its approach to maintaining accurate clinical records to ensure that it meets the requirements of The Health and Care Professions Council Standards of Practice.

d) Provides a reminder to all clinicians about the importance of good communication with those present at calls they attend.

e) Shares this report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.

f) Shares this report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learning from these recommendations in its Annual Duty of Candour report.

99. I am pleased to note that in commenting on the draft of this report **Welsh Ambulance Services University NHS Trust** has agreed to implement these recommendations.

Michelle Morris

Michelle Morris 4 March 2025
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