Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Northern Ireland Ambulance Service Trust

NIPSO Reference: 18783

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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EXECUTIVE SUMMARY

I received a complaint about the actions of the Northern Ireland Ambulance Service HSC Trust (NIAS) when responding to a 999 call after the complainant's father (the patient) had suffered a stroke.

I accepted the following issue of complaint for investigation:

Whether the care and treatment provided to the patient was appropriate and reasonable?

The investigation of the complaint identified a failure of care and treatment provided by the NIAS in respect of the following matters:

(i) Failure of the RRV to respond to a Category 'A' Red call within eight minutes

(ii) Failure to advise that the patient was FAST positive when requesting an ECV

(iii) Failure to immediately send ECV E723 to the patient upon receipt of a request

(iv) Failure to have an adequate oversight of the ECV's delay when responding to the patient.

I am satisfied that the maladministration I identified caused the patient to experience the injustice of distress, and the loss of opportunity to be assessed by the RRV Paramedic and ECV crew sooner. In this case I consider that the complainant is also a person aggrieved. As a result of the failings in his father's care and treatment, I am satisfied he suffered uncertainty.

Recommendations

I recommended the NIAS:

- Issued the complainant and the patient with an apology in respect of the injustice suffered
- Make a payment of £750 to the patient in respect of the injustice identified

- Updated its EOC Standard operating procedure, Section 30 – RRV Deployment, issued April 2014, to:
    I. Include a dual response (if the RRV is deployed first) to patients experiencing Stroke and Cardiac Symptoms;
    II. Ensure attending clinicians confirm that an ambulance back-up is required as soon as time critical incidents are identified;
    III. Include a clinical oversight to review calls waiting for back up within the dispatch queue.
- Shared the learning experiences as case studies and provided guidance to:
    I. RRV Paramedics on identifying FAST positive patients, highlighting the need to urgently request ECVs for patients who are FAST positive;
    II. DCOs in relation to the allocation of resources, detailing that withholding a resource for cover is an unsafe practice;
    III. DCMs in relation to keeping oversight, managing delays, and allocating resources appropriately;
    IV. The above staff on thrombolysis treatment, highlighting the importance of timing.
- Provided evidence of the progression of its public consultation to improve response times, levels of cover and quality of care to patients, including its proposed Clinical Response Model, and its engagement of a recruitment and training program to reduce reliance on overtime and to ensure staff comply with planned hours.

I am pleased to report that the NIAS accepted my findings and recommendations.

THE COMPLAINT

1. The complaint concerned the actions of the NIAS on 10 December 2016, when responding to a 999 call after the complainant's father (the patient) had suffered a stroke. The complainant explained that on this date, his father's neighbour phoned 999 at 10.29hrs requesting an ambulance for him. A Rapid Response Vehicle (RRV) arrived with the patient at 10.58hrs, and the RRV paramedic requested an Emergency Conveyancing Vehicle (ECV) at 11.25hrs. The complainant complained that the RRV paramedic failed to urgently request an ECV, which impacted on his father's health.

2. In addition, the complainant said that although the initial 999 call was categorised as urgent, requiring a response time of less than eight minutes, the ECV did not arrive with his father for two hours and 17 minutes. The complainant explained that the ECV arrived at 12.46hrs, left the scene at 13.08hrs, and arrived at the hospital at 14.01hrs. He complained that if the NIAS had transported his father to hospital in a reasonable timescale, he could have received thrombolytic therapy[1], and may not have been left severely disabled.

Issues of complaint

3. The issue of complaint which I accepted for investigation was:

Whether the care and treatment provided to the patient was appropriate and reasonable?

The following will be considered under the issue listed above:

(i) The time for the RRV to arrive

(ii) The time from when the RRV arrived to the time when the ECV was requested

(iii) The NIAS' decision to withhold the ECV for Belfast/ Lisburn Area

[1] The administration of drugs to break up or dissolve blood clots.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the NIAS all relevant documentation together with the NIAS' comments on the issues raised. This documentation included information relating to the NIAS' handling of the complaint.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice (IPA) from the following independent professional advisors:

(i) **The Health and Care Professions Council Registered Paramedic (P IPA)** BSc (Hons) Emergency Care, Emergency Practice, PTLLS, PG Cert Healthcare Leadership, Mc Para – Frontline Paramedic and Emergency Care Practitioner, Clinical and Quality Lead, and Silver Tactical Commander within the Ambulance Service.

(ii) **Registered Allied Health Professional, Paramedic (DCM IPA)** – 31 years' experience working within an NHS Ambulance Trust, NHS 111 helpline and secondary telephone triage. Qualified and extensive experience with emergency triage software. Operational management experience within Health and Operations Emergency Centres (Ambulance Emergency Control Centres).

(iii) **Consultant Cardiologist (C IPA)**, MB BS, MRCP, PhD – General Cardiologist with special interests in coronary intervention and coronary risk factor management.

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice'; however, how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

8. The general standards are the Ombudsman's Principles[2]:

(i) The Principles of Good Administration
(ii) The Principles of Good Complaints Handling
(iii) The Public Services Ombudsmen Principles for Remedy

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of NIAS whose actions are the subject of this complaint.

10. The specific standards relevant to this complaint are:

(i) NIAS' internal memo on *'Change in Timescale for Management of Patients Presenting with Acute Stroke Symptoms'*, dated 23 April 2013 (Timescale Memo)
(ii) NIAS' internal memo on *'Pilot Thrombectomy Service for Patients with Acute Stroke'*, dated 14 December 2016[3] (Thrombectomy Memo)
(iii) Emergency Ambulance Control's Standard Operating Procedures, Section 6, *'Allocating an Emergency, Urgent, and Routine Response'*, December 2016 (EAC SOP, Section 6)
(iv) Emergency Ambulance Control's Standard Operating Procedures, Section 30, 'RRV Procedures', August 2014 (EAC SOP, Section 30)
(v) National Institute for Health and Care Excellence (NICE) Guideline on Alteplase for treating acute ischaemic stroke, published on 26 September 2012 (NICE Guidelines on strokes)

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[3] Relevant at the time of this complaint

11. I have not included all of the information obtained in the course of the investigation in this report. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings. A draft copy of this report was shared with the complainant and the NIAS for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient was appropriate and reasonable?

The following will be considered under the issue listed above:

(i) The time for the RRV to arrive

(ii) The time from when the RRV arrived to the time when the ECV was requested

(iii) The NIAS' decision to withhold the ECV resource for Belfast/ Lisburn Area

12. The complaint concerned the actions of the NIAS when responding to a 999 call after the patient suffered a stroke. The complainant explained that on this date, his father's neighbour phoned 999 at 10.29hrs requesting an ambulance. He stated that a RRV arrived at 10.58hrs, and the RRV Paramedic requested an ECV at 11.25hrs. The complainant said that the RRV Paramedic failed to urgently request an ECV, which impacted on his father's health.

13. He also complained that although the initial phone call was categorised as urgent, requiring a response time of less than eight minutes, the ECV did not arrive for two hours and 17 minutes. The complainant explained that the ECV arrived at 12.46hrs, left the scene at 13.08hrs, and arrived at the hospital at 14.01hrs. He complained that if the NIAS had transported his father to hospital in a reasonable timescale, he could have received thrombolytic therapy[1], and may not have been left severely disabled.

Evidence considered

14. As part of the investigation, I have considered the NIAS' Timescale Memo, which states the following in relation to thrombolysis treatment:
'We have been advised that the Department of Health is endorsing the adoption of new guidance for the management of patients suffering an acute stroke, with the result that any patient presenting within ***four and a half hours***

of the onset of symptoms may now be considered for thrombolysis treatment in hospital…

Therefore, ambulance crews attending any patient in whom the symptoms of a potential stroke have arisen within the previous four and a half hours must regard them as a possible candidate for hospital thrombolysis… the vital role of an ambulance crew involves recognition of the possible diagnosis and the management of the situation as a time-critical emergency.

As such, crews are again reminded of the following five steps that are vital in securing the best outcome for patients with an acute stroke.

1. ***Any patient presenting within four hours of the onset of symptoms of a possible acute stroke must be regarded as a time critical emergency.***

2. ***The FAST test must be performed and recorded on the patient report form along with a blood glucose measurement. Crews must record the time of onset of a patient's symptoms and where possible encourage a family member to travel with the patient, but this must not delay transport****…*

15. I have also considered the NIAS' Thrombectomy Memo, which states that:

*'**Initial response by crews…***

It is important to stress that both stroke lysis and thrombectomy are time critical procedures…

- ***Between the hours of 0800 and 1730 (Monday – Friday only), patients who have developed symptoms of acute CVA [cerebrovascular accident][4] within the past twelve hours, and who are FAST-positive…*** *must still be brought to the nearest hospital offering a 24/7 stroke service for initial assessment.*

[4] A stroke.

- ***At all other times, all patients who present with the symptoms of an acute CVA within the previous four and a half hours, and who are FAST positive…*** *must be brought to the nearest hospital offering a 24/7 stroke service.'*

16. In addition, I considered the EAC SOP, specifically section 6, which relates to the allocation of resources:

'No patients are to be unnecessarily kept waiting. If there is an appropriate resource available they should be deployed…

6.1 Allocating an Emergency Response
… It is the Control Officer's responsibility, based on the category and type of call, to assign and ensure that the most appropriate resource is dispatched to the incident…

6.4 Allocating a Rapid Response Vehicle (RRV)
To assist with achieving the Category 'A' performance target RRVs should be deployed as follows…

- *RED Requests – Send both A&E and RRV resources only to Cardiac Arrest patients and Road Traffic Collision patients where multi-system trauma is known or suspected due to entrapment or ejection from a vehicle, where possible and appropriate. All other RED requests should be responded to with the nearest single resource. If this is a RRV the attending paramedic should assess the patient at scene before determining the assistance required.'*

17. I have also considered section 30 of the EAC SOP, which relates to staff responsibilities:

*'**30.3 Responsibility of Staff***
RRV Responders, as with staff generally, carry personal responsibility for ensuring that they work to the best of their abilities without casual mistakes… Personnel are expected to keep themselves up to date with best practice and

to maintain service quality…

30.7 Other Specific Considerations

…All emergency calls require the completion of a Patient Report Form… It is the responsibility of the Responder to ensure that the information relevant to their findings and actions/ inactions is recorded.'

18. Further, I considered NICE Guidelines on strokes, specifically in relation to the timeframes for treatment:

'Alteplase[5] is recommended within its marketing authorisation for treating acute ischaemic stroke in adults if:

I. treatment is started as early as possible within 4.5 hours of onset of stroke symptoms…

The Committee heard from clinical specialists that alteplase is more effective the earlier it is given to patients. The clinical specialists commented that, while extending the treatment window to 4.5 hours would enable more patients to be treated with alteplase, this might result in some patients who present early receiving delayed treatment and therefore not benefiting from alteplase to the extent that they might otherwise have. The clinical specialists and patient experts emphasised the importance of treating patients with acute ischaemic stroke as early as possible.'

19. I also considered a letter sent by a Consultant Geriatrician to the complainant on 29 March 2017:

'I viewed your father as outside the time window to receive thrombolysis (i.e. 4.5 hours from onset time of symptoms). Whilst our current protocol continues to have an upper age limit of 80yrs, we do lyse patients above this age on an individualised basis. Patients with an acute ischaemic stroke over 80yrs gain most benefit with lysis given within 3 hours… Your father had arisen from bed

[5] A thrombolytic drug used for the management of acute ischaemic stroke.

to toilet on 10/12/2016 [10 December 2016] at 08.15 and had fallen off the toilet. The clinical concern was that his fall had occurred on the basis of an acute stroke which either occurred at this time or possibly was present when he awakened from his sleep… I viewed your father's onset time as 08.15, although it may have been earlier and he was therefore outside the time window to receive intravenous thrombolysis.'

20. I have also considered the patient's discharge letter from the Ulster Hospital, dated 30 January 2017, which stated that *'he was not suitable for thrombolysis as it transpired that he was probably a wake up stroke.'*

21. In response to investigation enquiries, the NIAS was asked to comment on the complaint about the length of time that it took for the ECV to arrive. I have established the following chronology from the documentation provided by the NIAS:

10.29hrs: Emergency Medical Dispatcher (EMD) received the 999 call from the patient's neighbour
10.31hrs: RRV was dispatched by the NIAS
10.58hrs: RRV arrived with the patient
11.25hrs: RRV Paramedic requested an ECV
11.45hrs: ECV (E723) dispatched to an alternative emergency call
12.09hrs: ECV (E222) dispatched to the patient
12.46hrs: ECV (E222) arrived with the patient
13.08hrs: ECV (E222) left the scene
14.01hrs: ECV (E222) arrived at hospital

22. The NIAS also confirmed that it received a 999 call to attend the patient at 10.29hrs on 10 December 2016. It reported that the caller introduced himself as a doctor [the neighbour], and stated that the patient *'was confused, having fallen and was probably paralysed down one side.'* The caller explained that the patient was having a *'cerebral attack'*, he was semi-conscious, and that his symptoms had started approximately half an hour prior to the 999 call.

23. The NIAS explained that it uses the Medical Priority System to categorise 999 calls. The EMD works through a series of scripted questions and instructions, before applying a dispatch code to the patient. The NIAS stated that the dispatch codes are provided by the Department of Health's Emergency Call Prioritisation Group, and reviewed by the NIAS' Medical Director. The NIAS confirmed that its telephone and computer records indicate that the triage of the phone call was performed correctly. However, as the patient was not fully alert, it stated that it was not possible to perform the full telephone FAST assessment. The NIAS stated that the EMD coded the 999 call '*through the Stroke (CVA)/Transient Ischaemic Attack (TIA) protocol'*, as *'Category A Red… indicating a life threatening status with a target response time of eight minutes'.* In addition, the NIAS noted that it is policy to assign a paramedic to all Category A Red calls.

24. At the time of the 999 call, the NIAS confirmed that there were no ECVs available to respond in the Newcastle and Downpatrick areas. It stated that the nearest available response was a RRV crewed by a paramedic, which was located in Ballynahinch, and therefore this resource was allocated. The NIAS stated that the RRV was dispatched at 10.31hrs, with an estimated arrival time of 38 minutes.

25. The NIAS stated that the RRV arrived with the patient at 10.58hrs, a response time of 27 minutes and 15 seconds. It accepted that the response time was *'well below the expected standard of eight minutes for this category',* and apologised to the complainant for the slow response. The NIAS stated that on this occasion the RRV was the closest available resource with a paramedic.

26. The NIAS was asked by the Investigating Officer to respond to the complaint in relation to the length of time between the RRV's arrival with the patient, to the time the ECV was requested. The NIAS confirmed that the RRV arrived at 10.58hrs and the RRV Paramedic contacted the Emergency Ambulance Control (EAC) to request an ECV at 11.25hrs.

27. The NIAS explained that as part of its complaints process it interviewed the RRV Paramedic in relation to the timeframes. It stated that he explained that the *'patient was difficult to communicate with therefore a friend who was at the scene helped to give some history of the events leading to the call for an ambulance…it had also been challenging to fully assess the patient.'* As a result, the NIAS advised that it took a long time to establish what had happened prior to his arrival. The paramedic stated that he was made aware that the patient *'had woken with symptoms and he wanted to make sure of this information due to the implications for further treatment options, as at the time many of the stroke lysis centres viewed this as a potential exclusion criteria for thrombolysis.'*

28. The NIAS also stated that on review of the Patient Report Form (PRF) created by the paramedic, an Investigating Officer confirmed that he had completed an appropriate cardiovascular assessment and recorded the information appropriately. The NIAS stated that the Investigating Officer determined that *'it was a challenge to ascertain if the request for further resources could have been made earlier'.* However, the NIAS *'recognised that this may have aided the patient's long term health.'*

29. The NIAS also noted that the Investigating Officer recognised that *'pertinent clinical details, red flags and differential diagnosis were missed'* on the PRF. As a result, the NIAS referred the paramedic to the clinical training department, and assigned him a Clinical Support Officer for a minimum of six months to observe his practice on a weekly basis and quality assess his PRFs. The NIAS also stated that he was not permitted to work on the RRV until completion of the required training to ensure patient safety.

30. The NIAS was also asked to respond to the complaint in relation to the length of time between the request for an ECV, and the time that the ECV arrived on scene. The NIAS confirmed that an ECV (E222) was dispatched at 12.09hrs and arrived at 12.46hrs.

31. Upon receipt of the request, the NIAS stated that only one ECV was available to provide cover for the Belfast, Lisburn, and North and South Down areas. It stated that due to a shortage of emergency crews in the Newcastle and Downpatrick areas (there was one day-crew as opposed to the planned three), the availability of emergency crews was considerably affected. The NIAS stated that *'the use of a non-emergency ambulance for conveyancing would not be considered a viable option as this vehicle does not have audible and visible warnings fitted and therefore is unable to drive under emergency conditions.'*

32. In this instance, the NIAS stated that the EAC's Duty Control Officer (DCO) decided to hold an ambulance to provide cover for the Belfast/ Lisburn area, *'given the distance to Ardglass and the potential for an immediately life threatening call in the Greater Belfast area being received.'* It explained that *'a contributory factor'* in making this decision was the fact that a paramedic was with the patient.

33. In relation to the management of the allocation of resources, the NIAS stated that the EAC *'use predictive analysis for status planning'.* It explained that the Lisburn/ Belfast area appears higher on the Status Plan Management system than the Downpatrick/ Ballynahinch area, when predicting the location of the next emergency call. The NIAS stated that this prediction is *'based on patterns of demand in the past.'*

34. The NIAS explained that a second ECV cleared at the Royal Victoria Hospital (RVH) at 11.31hrs, and *'the intention had been to dispatch this crew'* to the patient. The NIAS noted that this vehicle required restocking and cleaning due to the nature of its previous call, which *'took approximately 38 minutes to complete.*' Following cleaning, the NIAS stated that the ECV was dispatched as *'it was 12 – 15 minutes closer to Ardglass'.*

35. In response to investigation enquiries the Duty Control Officer stated that '*As controller, it is laid plainly at my feet where the ambs [ambulances] are sent. On that day at that time, [E1 and E2] were the only ambs [ambulances] avail [available]. [E1] was available between Lisburn and Belfast as cover for*

upward of half a million people, [E2] was in station, Purdysburn, cleaning their stretcher mattress… Once this was done [E2] was going to be sent… as it was 12 – 15 minutes closer to Ardglass than [E1]… In closing… this problem, which is chronic in NIAS… occurred due to the aforementioned staff shortages in the immediate geographical region, not staff shortages in any other NIAS area, and it did not happen because an EMD chose not to allocate an amb [ambulance] as it is not their job to do so.'

36. The NIAS stated that the decision to hold ambulance [E1] *'was not best practice'*. It stated that it sent the complainant a letter on 30 November 2017, apologising for *'a flawed decision by the Duty Control Officer when faced with limited resources to meet demand for emergency response and cover at that particular time'*. In addition, the NIAS stated that the Investigating Officer of the complaint, a Duty Control Manager, discussed the need to balance *'the provision of cover and allocating outstanding calls in a challenging situation'* with the Duty Controller.

37. The NIAS also stated that the Investigating Officer recommended that '*this example be used as part of a case study review at Post Proficiency of CPD training in relation to how the medical model used to record patient's details can support the Clinician*.' The NIAS stated that it has *'commissioned a review of capacity to make the case for additional investment'* to improve response times, levels of cover and quality of care provided to patients. This review has been completed, and the NIAS *'has engaged with HSCB [the Health & Social Care Board] and DoH [the Department of Health] around related potential funding implications and is in the process of preparing to undertake a public consultation on the associated proposals, including its proposed Clinical Response Model (CRM).'* Finally, the NIAS stated that it is *'currently engaging in a comprehensive recruitment and training program'* to *'reduce reliance on overtime and ensure [staff] compliance with planned hours'.*

Independent professional advice

38. As part of the investigation, I received independent professional advice from an experienced Paramedic (P IPA), a Duty Control Manager with over 30 years' experience (DCM IPA) and a Consultant Cardiologist with a specialist interest in coronary risk management (C IPA). The P IPA considered the care and treatment provided to the patient following the arrival of the paramedic on scene to the time the ECV was requested. In addition, the DCM IPA considered the decisions to allocate the RRV and to withhold the ECV, and the C IPA considered the overall effect the delays had on the patient's access to thrombolysis treatment.

39. On review, I note the DCM IPA provided the following chronology of events:

'**10.29:** 999 call to NIAS from the patient's neighbour…
10.31: Rapid Response Vehicle (car with single Paramedic) dispatched…
10.55: Ambulance (Call sign [E1]) cleared at Belfast Hospital and dispatcher requested they return to Lagan Valley to provide cover
10.58: Rapid Response Vehicle arrived at the patient's address
11.25: Paramedic on scene called ambulance…
11.45: Ambulance [E1] dispatched to an alternative emergency call
12.04: First Computer Aided Dispatch (CAD) search for the nearest available ambulance to attend to the patient
12.11: Second CAD search and Ambulance Call sign [E2] dispatched
12.46: [E2] arrived at the patient's address

40. The DCM IPA advised that the 999 call made to the NIAS was *'correctly triaged and prioritised'.* However, the DCM IPA advised that the *'NIAS failed to achieve the expected response time to arrive within eight minutes'.* The DCM IPA noted that *'ambulance availability was depleted due to sickness [however] the first available resource was deployed and attended',* as *'confirmed by the RES Resource List at 10.31 on the SOE [sequence of events from CAD[6]]'.*

[6] Computer aided dispatch system.

41. On review of the records, the DCM IPA also advised that the Duty Control Officer adhered to the EAC SOP, Section 6, *'to send a single response to an incident unless it is a Cardiac arrest or road traffic collision with multiple requirements.'* The DCM IPA advised that *'all other eight minute calls will receive a single response and if this is a Rapid Response Vehicle the attending paramedic should assess the patient at scene before determining the assistance required.'*

42. The P IPA advised that upon arrival with the patient at 10.58hrs the paramedic documented that his symptoms were *'those indicative of a CVE [cerebrovascular event] (stroke).'* Specifically, the P IPA advised that he noted *'The patient had facial weakness and speech impairment… [and] a GCS [Glasgow Coma Scale[7]] score of 15.'* The P IPA advised that the GCS score indicates that the patient *'was fully alert and conscious and remained that way until the last recorded time of assessment at 12.30 on the first attending paramedic's paperwork.'*

43. In addition, the P IPA advised that the PRF, *'contemporaneously records that a level of consciousness, pain score, pulse, blood pressure, blood sugar, FAST test, ECG (heart trace), respiratory rate, breath sounds and a medical and medication history were taken'.* The P IPA confirmed that *'the observations were repeated at reasonable intervals to monitor for any deterioration',* and that all aspects of the CVE assessment were completed and documented appropriately. The P IPA also advised that the documented paramedic assessment was in accordance with the Joint Royal College Ambulance Liaison Committee Guidelines.

44. As part of enquiries, the P IPA was asked to respond to NIAS' investigation findings that pertinent clinical details, red flags and differential diagnosis were missed by the paramedic. The P IPA advised that the PRF completed was *'adequate',* and contained *'all the relevant information and assessments that would be expected of a paramedic assessing a patient who has suffered a suspected stroke.'* The P IPA advised that the *'main difference in assessment*

[7] A neurological scale which aims to give a reliable and objective way of recording the conscious state of a person.

and treatment plan' between the PRF and the PRF completed by the ECV crew was that the ECV crew *'decided to immobilise the patient based on the documented pain to the hip and neck area which the first attending paramedic did not identify or feel required immobilisation.'* The ECV's PRF noted that *'according to RRV, patient not complaining of C spine pain.'* Therefore, the P IPA advised that this is evidence that the paramedic had considered cervical spine pain *'an indication that immobilisation is likely to be required, but at that time it was not indicated.'*

45. The P IPA also advised that *'it is not unusual for patient presentations to change over time.'* The P IPA advised that *'if the patient is not complaining of C spine pain (as on the initial assessment by the first paramedic […], careful consideration has to be given before immobilising as a precaution as immobilisation itself can bring its own hazards.'* The P IPA advised that the '*decision to not immobilise was reasonable.'* The P IPA advised that *'this difference in results of assessment, clinical judgement and treatment plan for a changing patient presentation were not relevant to the patient outcome.'*

46. The P IPA also advised that the only other difference between the two PRF's was that *'although both record a FAST positive patient',* the paramedic's PRF documented that there was *'no arm weakness'.* In comparison, the P IPA advised that the ECV's PRF indicates arm weakness. The P IPA advised that *'in both cases arm weakness was assessed.'* The P IPA also advised that the fact that it was identified in the ECV's PRF was *'an indication of a potentially deteriorating patient – not an indication that it was missed first time around.'*

47. The P IPA also advised that the only omissions noted on both PRF's are the patient's date of birth and the NEWS score. However, the P IPA advised that the patient's age was recorded, and *'this omission would have no bearing on clinical delivery.'* In relation to the NEWS score, the P IPA advised that *'it is not essential as deterioration would be noted from any change in observations as they were taken.'* The P IPA also advised that there *'is a variation'* between the GCS scores recorded on the two PRFs. The P IPA advised that the paramedic's PRF records a score of 15 *'fully conscious and alert'*, whereas

the ECV's PRF records a score of 14 *'minor single indicator of potential reduced level'.*

48. As part of investigation enquiries, the P IPA was asked if it was reasonable for the paramedic's assessment of the patient to have taken 27 minutes. The P IPA advised that *'without being present on scene and therefore not having a full picture of the difficulties faced by the paramedic in obtaining a history and undertaking the observations required to gain a sufficient picture to allow a care plan to be formed, it is difficult to say whether 27 minutes in this particular case was reasonable.'* However, the P IPA advised that *'it is not unusual for a patient assessment to take this period of time and the patient report form documents that the patient had difficulty understanding other people so this would obviously have made gaining a history more difficult and therefore time consuming.'*

49. The P IPA advised that there would be '*no advantage for a solo paramedic to delay requesting back up, especially as there is only so much a paramedic on their own can do on scene, so the quicker back up is requested, the sooner the patient can be transferred to a place of care.'* In addition, the P IPA advised that *'it is a poor patient experience and stressful for the paramedic to have to wait extended periods of time for back up and transport to hospital so I can see no reason why the paramedic would delay a request for help.'*

50. The P IPA advised that in considering all the evidence *'27 minutes would not appear to be unreasonable'.* The P IPA noted that *'it is important that the RRV makes an appropriate decision to request back up because this obviously then depletes available resources from attending other emergencies so it is important that they only request once they are sure hospital is required and this can take time.'* In addition, the P IPA advised that a request for the ECV at 11.25hrs was *'the appropriate care pathway plan for a patient presenting as the patient did.'*

51. As part of investigation enquiries, the P IPA was also asked if the paramedic ought to have performed any other actions at this time. The P IPA advised

that '*the paramedic on scene has no knowledge of the pressures on other areas of the service and can therefore only request back up... the paramedic on scene can have no decision input into when they get sent support. This is for the control room (who have the overall picture) to manage. The paramedic on scene can only undertake an assessment and based on this ask for appropriate support based on their particular patient needs.'* The P IPA also advised that there were *'no further actions or assessments that could have been done in the pre hospital setting which would have benefited the patient or enhanced the paramedic's ability to further diagnose or treat the patient.'*

52. The P IPA further advised that the paramedic did not administer medication *'other than to site a cannula which requires a small amount of saline to 'flush' the cannula'.* The P IPA advised that this *'is good practice as it allows intravenous access should the patient deteriorate and require rapid drug administration.'* The P IPA also advised that when the ECV arrived, the second crew *'administered ondansetron which prevents nausea and vomiting which would be appropriate before conveying an unwell patient for a significant distance.*' The P IPA confirmed that it was appropriate that no other medication was provided to the patient at this time.

53. In relation to the request for an ECV, the DCM IPA advised that *'the dispatcher followed the agreed Standard Operating Procedure and did not provide ambulance back up until requested.'* However, the DCM IPA advised that when the paramedic requested the ECV, he did not *'declare that the patient was suffering from stroke symptoms, or that he was FAST positive.'* The DCM IPA also advised that when the dispatcher informed the paramedic that an estimated time for arrival for the ECV was not available, the paramedic had '*no sense of urgency.'* The DCM IPA noted that the paramedic *'received feedback and support… [was] placed onto a monitored action plan and was withheld from working alone for six months.'*

54. Overall, the P IPA advised that the paramedic *'acted appropriately and undertook all actions and assessments that could reasonably be expected of a solo responder.'* The P IPA further advised that his *'actions in providing*

personal care for the patient also demonstrated an empathic and caring approach as this would not necessarily be expected to be undertaken within an emergency call.' However, as noted above, the DCM IPA advised that the paramedic did not communicate *'the severity of [the patient's] condition'* to the dispatcher when requesting the ECV.

55. In relation to the Duty Control Officer's decision to withhold [E1] to cover the Belfast/ Lisburn areas, the DCM IPA advised that this *'was not a reasonable one and was an un-safe decision'.* The DCM IPA advised that information provided at the time of the 999 call, *'declared obvious stroke symptoms which are time critical due to the potential for thrombolysis treatment. The timeframe for this treatment is within four hours and thirty minutes from the onset of symptoms.'* In addition, the DCM IPA advised that the Duty Control Officer, *'assumed that the paramedic and off duty doctor were adequate when withholding [E1]… however, neither medics with the patient were able to offer any more than comfort and observations whilst awaiting transportation to hospital.'*

56. The DCM IPA further advised that there were a number of other issues which contributed to the delay the patient experienced, including the time taken for the paramedic to request backup. The DCM IPA advised that '*some of the responsibility should… lie with the Duty Control Manager […] as his role is to manage and supervise the call centre, support staff and monitor delays.'*

57. The DCM IPA advised that he was not aware of the delay in sending the ECV *'until the complainant called, so did not have a clear oversight of the shift he was managing.'* Therefore, the DCM IPA advised that *'the Dispatcher [the Duty Control Officer] had no support attempting to manage the delayed responses.'* The DCM's role, as noted by the DCM IPA, includes *'liaising with the control officers when resources are scarce and support[ing] decisions for [the] correct allocation of resources.'*

58. The DCM IPA also advised that the Duty Control Manager *'was unprepared to discuss the delay [with the complainant]… however the Trusts only response*

was to remind him about the need to maintain appropriate levels of professionalism at all times whilst on duty.' The DCM IPA advised that the paramedic '*was placed on an appropriate robust action plan but both the Control Officer [The Duty Control Officer] and Duty Manager were "reminded" with no further action.'* The DCM IPA advised that the actions of the Duty Control Officer appear to have *'not been addressed.'*

59. As part of investigation enquiries, the DCM IPA was asked to identify any learning and/ or service improvements that could be made. Following a review of the case, the DCM IPA advised the following:

(i) Review and amend the EOC Standard Operating Procedure, Section 30 – RRV Deployment, issued April 2014, to *'include a dual response (if the RRV is deployed first) to patients experiencing Stroke and Cardiac Symptoms. These patients are time critical and awaiting confirmation from the attending clinician that an ambulance is required will delay the opportunity for time critical thrombolysis for stroke symptoms or treatment for cardiac events.*

(ii) *Provide a Standard Operating Procedure for attending clinicians to confirm an ambulance back-up is required as soon as time critical incidents are identified.*

(iii) *Provide a clinical oversight within the EOC to review calls waiting for back up within the dispatch queue.*

(iv) *A robust action plan has been provided to the Paramedic who attended on the RRV but the learning from this incident could be shared as a case study.*

(v) *The Control Officer (Dispatcher) [The Duty Control Officer] was reminded of the principle of not holding back a resource for cover but learning from this incident has not been shared. No assurance has been provided that withholding a resource for cover is an unsafe practice, therefore there is a high probability that this would happen again. A clear process needs to be documented for the dispatchers to adhere to rather than remind them of the principle.*

(vi) *The Duty Manager with whom the complainant discussed the delay… was unaware of the serious delay or the Dispatchers decision to withhold the available ambulance. This has not been addressed.'*

Effect of delays on the patient's health and wellbeing

60. As part of investigation enquiries, the C IPA was asked what effect the delays detailed above had on the patient's health. The C IPA advised that *'there seems little doubt that where thrombolysis [would] have been possible, the delays caused by [the NIAS] potentially contributed to adverse patient outcomes.'* On review of the hospital medical records, the C IPA advised that *'it seems that [the patient] would have been a candidate for thrombolysis.'*

61. The C IPA advised that *'the time required to assess the patient, check the INR [Internationalised Normalised Ratio] and perform and report a CT scan (all absolutely vital before potential thrombolytic treatment) appears to be about 45 minutes in the institution.'* As a result, the C IPA advised that *'if the time of stroke onset is perceived as 08.15, then [The patient] would have to arrive at hospital by mid-day to receive treatment.'*

62. The C IPA advised that *'the call time to the ambulance service is documented as 10.29, already 2 hours and 14 minutes into the 4 and a half hour time window for possible lysis. If a reasonable ambulance response, assessment and transfer to hospital would have taken 90 minutes then… clinical outcomes would not have altered and although the service was extremely poor, the outcome ultimately was not changed.'* However, the C IPA advised that if *'the ambulance would have arrived at hospital before 12.00 without the delays incurred, then the patient has been unreasonably denied the small possible benefit of lytic therapy.'*

63. The C IPA advised that data has shown that *'in eligible patients, treatment with thrombolysis for acute stroke within three hours of symptom onset leads to a 16% reduction in unfavourable outcomes as measured by the modified Rankin score (a score assessing disability).'* Between three and four and a half hours after system onset, the C IPA advised that *'the effect is less powerful'*, with a *'reduction in disability of approximately 7%.'* The C IPA advised that it is not deemed effective to treat patients with thrombolysis after four and a half hours of symptom onset. However, the C IPA advised that the

'outcome in patients with acute ischaemic stroke is significantly better in those who undergo thrombolysis compared with those who do not.'

64. When considering thrombolysis, the C IPA advised that *'time is critical… with the best outcomes occurring within the first 90 minutes and decreasing thereafter.'* The C IPA advised that these timeframes are affirmed by NICE Guidelines on strokes, which recommend that *'treatment is started as early as possible' once haemorrhage is excluded up to a time window of 4.5 hours after the onset of symptoms.'*

65. The C IPA also advised that some consider thrombolytic therapy in the elderly to be less effective and safe, although *'most centres do not have an upper limit of age for treatment.'* The C IPA advised that *'the difference in risk with lysis in the elderly has been subject to variable estimates from no difference to an approximately 5% greater risk of intracranial haemorrhage. Clearly this potentially mitigates the overall benefit from early lysis to a degree.'* However, the C IPA advised that *'Increasing age is associated with poorer outcome but the association between thrombolysis treatment and improved outcome is maintained in very elderly people. Age alone should not be a barrier to treatment.'*

66. In conclusion, the C IPA advised that *'it seems [the patient] had a prior good quality of life, had no contraindications to thrombolysis, and there was no haemorrhage on the CT scan.'* In this case, the C IPA advised that *'if an undelayed ambulance would have arrived at hospital before 12.00, then the delays in transport of the patient to hospital potentially reduced the chances of disability reduction.'* The C IPA advised that *'it is impossible to precisely say what the percentage chance of this was, but theoretically the patient would have presented in the 3-4.5 hour time window with more prompt transfer (allowing time for CT scanning etc) and so allowing for a small increase risk of haemorrhage then it seems likely that there was a denial of an approximately 5% chance of disability reduction.'*

67. However, the C IPA advised that *'if with the required paramedic time on the scene and transfer to hospital promptly, then the patient would still have arrived after 12.00, then although the delays have been distressing, the outcome has not been greatly affected.'*

68. In response to the IPA findings, the NIAS stated that it *agreed 'with their conclusions that the clinical care provided at scene to the patient was appropriate.'* The NIAS stated that *'the greater concern in this case has always been the response times for conveying resource and the delay in arrival at hospital which may have impacted on the availability or effectiveness of thrombolytic therapy.'* In relation to the delay, the NIAS Medical Director stated that *'I would yet again apologise on behalf of NIAS… to both [the patient] and to [the complainant] for any distress we have caused.'*

69. The NIAS stated that *'at the time of this incident the criteria for consideration for intravenous thrombolysis included patients who had developed symptoms within the previous four and a half hours.'* It stated that *'during the initial telephone call it was reported to NIAS Emergency Medical Dispatcher that the onset of the patient's symptoms was at around 10am, but he ultimately arrived at hospital [within] approximately four hours.'* The NIAS explained that this placed the patient *'within the window of opportunity for lysis'.* However, the NIAS advised that *'the onset of symptoms was later understood to be earlier in the morning.'* The NIAS stated that it *'absolutely accept[s] that the timing should not be regarded as a simple absolute, and that the quickest possible transfer and hospital assessment is always preferable in cases of acute stroke.'*

70. At the time of this incident, the NIAS also advised that *'a relatively new thrombectomy service was operating in Northern Ireland… offering intervention to patients who were within 12 hours onset of symptoms, but was only available Monday to Friday between the hours of 0800 and 1730 and would therefore not been an option on the Saturday of this call.'*

Responses to draft report

71. A draft investigation report was issued to both the complainant and the NIAS for comment on factual accuracy. The comments submitted by both the complainant and the NIAS were taken into account as part of my final consideration of the complaint.

NIAS' response

72. The Chief Executive (CE) of the NIAS stated that *'I can confirm that I have considered the report in full along with the NIAS Medical Director […] and we accept the findings and recommendations that have been made.'*

73. The CE stated that '*through the adoption of the new Clinical Response Model, NIAS is hoping not only to improve response times in general to patients of all categories, but also to specifically ensure that a conveying resource arrives more rapidly in those situations where one is likely to be necessary. A specific example that we use to demonstrate this scenario is that of a patient suffering an acute stroke where there is a very strong likelihood from the outset of the call that rapid transport to hospital is vital to ensure the best clinical outcome. Where a similar approach has been taken in England, the overall time from the receipt of the 999 call to arrival at a stroke lysing unit has decreased. It is the intention of NIAS to make the necessary changes to our response code set in the near future, although the full implementation of the Clinical Response Model will be subject to approval by the Department of Health NI.'*

74. In addition, the CE stated that the *'NIAS has previously advised the Coroner of a process of clinical review of calls which are awaiting a response beyond their anticipated timeframe. This is undertaken by paramedics working on the Clinical Support Desk within the NIAS Emergency Ambulance Control Centre.'*

75. Finally, the CE stated that *'I would assure you that I treat this report and the findings contained herein very seriously. I would take this opportunity to once again convey my apologies to the complainant for any distress that we have caused.'*

Dispatcher

76. In response to the dispatch of the ECV, the Duty Control Officer stated that *'The RRV requested an A and E ambulance, as is [the case] with approx. [approximately] 80% of RRV calls. In an ideal world [the patient] would have gotten his transport [in] a lot shorter time. However the NIAS does not have an infinite number of ambulances, and on that day 50% of the allotted vehicles were short in that specific area. This meant City ambulances had to move into the country to cover country calls, leaving the city [short of] cover. This is the crux of the problem in this complaint, shortage of ambulances, and it is the reason we are all reading and writing about this incident today.'*

77. The Duty Control Officer further explained that *'[E1], was not held only for cover in the Lisburn/ Belfast Area, it was held for cover for all areas in the East City and East Country Divisions, which as stated [has] upwards of 275,000 people in it'.* He also stated that *'there is not a chance [E1] would have made the trip to Ardglass in less than 50mins, my reasoning is thus, Lisburn to Ballynahinch B class roads, 14 miles, Ballynahinch to Downpatrick, B class roads at best, another 14miles, Downpatrick to Ardglass 8 miles, B class roads again. 222 was a purdysburn stn [station] to Downpatrick 17miles, A class roads then onto Ardglass.'*

78. In addition, the Duty Control Officer commented on NIAS' comment that it is seeking additional investment to help with staffing levels. The Duty Control Officer stated that *'this incident occurred almost three years ago and simply put, nothing has changed in respect to staffing levels, this issue has become far worse now than I can ever remember it.'* The Duty Control Officer also referred to paragraph 119, and said that *'I can assure you I have been spoken to by no-one within NIAS about this call, other than the on duty DCM.'*

79. Finally, the Duty Control Officer stated that *'I would like to add my regret this incident has happened, and hope this goes someway to throwing new light as to the reasons why this regretful episode happened at all.'*

Duty Control Manager

80. In response to the draft report, the Duty Control Manager stated that *'there are aspects, which I accept. I accept that, upon reflection, I could have offered more sympathy to [the complainant] at the time of our telephone call.'*

81. However, in relation to his oversight of the ECV's delay, he said that *'I do not routinely analyse each call under the management of the Control Officer. This is because my role contains many other functions. If I were to analyse each call and subsequent dispatch decisions, I would be unable to undertake the functions of my post and would be deemed as inept by my line manager.'* On review of the response, the DCM IPA stated that '*I would not expect the Duty Manager to analyse every call, however, the expectation would be that the Duty Manager is made aware of significant delays by the EMD [Emergency Medical Dispatcher] Supervisor. Ultimately the responsibility lies with NIAS and the individuals it employs.'*

Analysis and Findings

82. I have carefully considered the complaint in relation to the care and treatment provided to the complainant's father by the NIAS on 10 December 2016. In order to investigate, I considered the: (i) time for the RRV to arrive; (ii) time from when the RRV arrived to the time when the backup ECV was requested; (iii) decision to withhold the ECV for Belfast/ Lisburn Area; and (iii) effect of the delays on the patient's health

Time for the RRV to arrive

83. The complaint concerned the actions of the NIAS when responding to a 999 call after the patient had suffered a stroke on 10 December 2016. On this date, the patient's neighbour phoned 999 at 10.29hrs to request an ambulance, and a RRV arrived at 10.58hrs. I note the NIAS confirmed these timeframes. In order to investigate this aspect of the complaint, I considered the categorisation of the 999 call, the decision to allocate an RRV, and the delay in the RRV arrival.

Categorisation of the 999 call

84. In relation to the categorisation of incoming calls, I note the NIAS explained that it uses the Medical Priority System. It explained that the EMD follows scripted questions and instructions in order to apply a dispatch code to the patient. In this instance, I note the NIAS stated that the caller advised the EMD that the patient was having a *'cerebral attack', 'was confused, having fallen and was probably paralysed down one side.'*

85. On review of telephone and computer records, I note the NIAS stated that the patient's 999 call was conducted correctly. However, it stated that a full telephone FAST assessment could not be performed as the patient was not fully alert. The NIAS stated that the EMD subsequently coded the call *'Category 'A' Red', 'indicating a life threatening status.'* On review of the available evidence, I note the DCM IPA advised that the NIAS *'correctly triaged and prioritised'* the call, and I accept the IPA's advice.

Decision to allocate an RRV

86. At the time of the 999 call, I note the NIAS stated that there were no available ECVs in the Newcastle and Downpatrick areas. As a result, the NIAS stated that it allocated its nearest available response, an RRV crewed by a paramedic and located in Ballynahinch. I note the NIAS stated that its policy is to assign a paramedic to all *'Category 'A' Red' calls,* and explained that this was the closest and only paramedic available.

87. I refer to Section 6.1 of the EAC SOP which states that '*It is the Control Officer's responsibility, based on the category and type of call, to assign and ensure that the most appropriate resource is dispatched to the incident.'* I also refer to Section 6.4, which relates to the allocation of RRVs. It states that '*RRVs should be deployed as follows… RED Requests – Send both A&E and RRV resources only to Cardiac Arrest patients and Road Traffic Collision patients where multi-system trauma is known or suspected due to entrapment or ejection from a vehicle, where possible and appropriate. All other RED*

requests should be responded to with the nearest single resource. If this is an RRV the attending paramedic should assess the patient at scene before determining the assistance required.'

88. I note the DCM IPA also advised that *'ambulance availability was depleted due to sickness [however the first available resource was deployed and attended [as] confirmed by the RES Resource List.'* Therefore, as per the EAC SOP, I accept the IPA's advice that the NIAS allocated *'the first available resource'* appropriately crewed with a paramedic.

Delay in the RRV arrival

89. I note the NIAS stated that a *'Category 'A' Red'* code, has *'a target response time of eight minutes'.* However, an RRV was dispatched to the patient at 10.31hrs, and arrived 27 minutes and 15 seconds later, at 10.58hrs. I note the DCM IPA advised that the '*NIAS failed to achieve the expected response time to arrive within eight minutes'* for a red flag call.

90. On review, I accept the IPA's advice that the NIAS failed to respond to the patient within the expected response time. I consider this failure constitutes a failure in the patient's care and treatment. As a result of the NIAS' failure to respond within the expected timeframe, I consider that the patient suffered the injustice of distress and loss of opportunity to be assessed earlier by the RRV paramedic. I will consider what impact this delay had on the patient's health later in this report. I consider that the complainant is also a person aggrieved. That is because, as a result of the failure in his father's care and treatment, I am satisfied he suffered the injustice of uncertainty.

91. In response to investigation enquiries, I am pleased to note that the NIAS has apologised to the complainant for the slow response time and accepted that its response was *'well below the accepted standard of eight minutes'.* The NIAS has stated that it is looking to improve its response times, levels of cover and quality of care by seeking *'additional investment'.* I note the NIAS has also specified that it is engaging in recruitment and training to ensure staff comply with their scheduled hours, and to reduce a *'reliance on overtime'.*

92. The complainant also complained that following arrival of the RRV at 10.58hrs, the paramedic did not request an ECV until 11.25hrs. I note the NIAS confirmed these timeframes. In addition, I note that as a result of the paramedic failing to urgently request an ECV, the complainant said his father's health was negatively impacted.

93. Following arrival at the scene, I note the P IPA advised that the paramedic recorded that the patient's symptoms were *'indicative of a CVE (stroke)… The patient had facial weakness and speech impairment.'* On review of the paramedic's PRF, the NIAS confirmed that an appropriate cardiovascular assessment had been completed and appropriately recorded. I note that this was confirmed by the P IPA.

94. I also note the P IPA advised that the paramedic's PRF was *'adequate'*, and *'contemporaneously records that a level of consciousness, pain score, pulse, blood pressure, blood sugar, FAST test, ECG (heart trace), respiratory rate, breath sounds and a medical and medication history were taken… [and] repeated at reasonable intervals to monitor for any deterioration.'* I refer to the NIAS' Timescale Memo, which states that '*the FAST test must be performed and recorded on the patient report form along with a blood glucose measurement',* for patients with an acute stroke. In addition, I note the P IPA advised that the paramedic's assessment was in in accordance with the Joint Royal College Ambulance Liaison Committee Guidelines.

95. However, I note the NIAS stated that on review of the paramedic's PRF it identified that *'pertinent clinical details, red flags and differential diagnosis were missed'.* As a result, the NIAS explained that it referred the paramedic for additional training, and did not permit him to work on the RRV until completion. On review, I note the P IPA advised that the *'main difference in assessment and treatment plan'* between the paramedic and the ECV PRFs was that the ECV crew immobilised the patient due to pain in his hip and neck area, whereas the paramedic did not. However, I note the P IPA advised that the ECV's PRF recorded that the paramedic stated the patient was not

complaining of C spine pain, indicating that he had considered it. I note the P IPA advised that *'it is not unusual for patient presentations to change over time… [and] this difference in results of assessment, clinical judgement and treatment plan for a changing patient presentation were not relevant to the patient outcome.'*

96. I note also that the P IPA advised that although the RRV's PRF records that the patient was a FAST positive patient, it does not document *'arm weakness'*, whereas the ECV's PRF does. However, I note the P IPA advised that arm weakness was assessed by the paramedic, and stated that the onset of arm weakness was *'an indication of a potentially deteriorating patient – not an indication that it was missed first time around.'* Therefore, on the balance of probabilities, I consider that it is likely that the patient's symptoms had changed over time and this led to the difference in the paramedic and the ECV crew's PRFs.

97. I note the P IPA also advised that the only omissions on both PRFs are the patient's date of birth and NEWS score. However, I note the P IPA advised that his age was included, and stated that '*this omission would have no bearing on clinical delivery.'* In addition, the P IPA advised that *'it is not essential [to include the NEWS score] as deterioration would be noted from any change in observations as they were taken.'* I therefore accept the P IPA's advice that the omissions of the patient's date of birth and NEWS had no bearing on the care and treatment he received.

98. I refer to Section 30.7 of the EAC SOP, which states that '*All emergency calls require the completion of a Patient Report Form… It is the responsibility of the Responder to ensure that the information relevant to their findings and actions/ inactions is recorded.'* Based on the available evidence, and the IPA's advice, I accept that the paramedic's PRF was *'adequate'* and that he completed and recorded an appropriate cardiovascular assessment. Further, although the paramedic did not immobilise the patient, I accept the P IPA's advice that he did consider this intervention as he had recorded the patient was not complaining of pain. I also accept the IPA's advice that the omissions

of the patient's date of birth and NEWS score on both PRFs had no impact on the care and treatment he received.

99. I also note the P IPA advised that the paramedic recorded that the patient had *'a GCS [Glasgow Coma Scale[7]] score of 15 [indicating that he was]… fully alert and conscious and remained that way until the last recorded time of assessment at 12.30 on the first attending paramedic's paperwork.'* However, I note the P IPA advised that there was a slight variation of this score in the ECV's PRF, which recorded a score of 14, *'minor single indicator of potential reduced level'.* I consider that this variation in GCS score highlights the change in the patient's condition.

100. In relation to the administration of appropriate medication, I note the P IPA advised that the paramedic did not administer medication *'other than to site a cannula which requires a small amount of saline to 'flush' the cannula'.* I note the P IPA advised that this *'is good practice as it allows intravenous access should the patient deteriorate and require rapid drug administration.'* I note the P IPA also advised that there were no further medications '*actions or assessments that could have been done in the pre hospital setting which would have benefited [the patient] or enhanced the paramedic's ability to further diagnose or treat [him].'*

101. I also note the NIAS stated that *'it was a challenge to ascertain if the request for further resources could have been made earlier'* Similarly, I note the P IPA notes that *'without being present on scene and therefore not having a full picture of the difficulties faced by the paramedic… it is difficult to say whether 27 minutes in this particular case was reasonable.'* However, I note the P IPA advised that *'it is not unusual for a patient assessment to take this period of time and the patient report form documents that the patient had difficulty understanding other people so this would obviously have made gaining a history more difficult and therefore time consuming.'*

102. On consideration of the evidence, I note the P IPA advised that 27 minutes would appear to be a reasonable time to request the ECV, and that it was an

'*appropriate care pathway plan for a patient presenting as [the patient] did.'* I note the P IPA advised that there would be '*no advantage for a solo paramedic to delay requesting back up… it is a poor patient experience and stressful for the paramedic to have to wait extended periods of time for back up and transport to hospital.'* In addition, I note the P IPA advised that *'it is important that the RRV makes an appropriate decision to request back up because this obviously then depletes available resources from attending other emergencies.'* On review, I accept the IPA's advice that the paramedic requested the backup within a reasonable period of time. On the balance of probabilities, I consider it is likely that the paramedic's assessment of the patient took this length of time due to difficulties in communicating with the patient.

103. Overall, I note the P IPA advised that the paramedic '*acted appropriately and undertook all actions and assessments that could reasonably be expected of a solo responder.'* I also note the P IPA advised that the paramedic's *'actions in providing personal care for [the patient] also demonstrated an empathic and caring approach as this would not necessarily be expected to be undertaken within an emergency call.'*

104. I also note the DCM IPA advised that *'the dispatcher [DCO] followed the agreed Standard Operating Procedure and did not provide ambulance back up until requested.'* However, the DCM IPA advised that during the paramedic's request for an ECV, he did not *'declare that [the patient] was suffering from stroke symptoms, or that he was FAST positive.'* I note the DCM IPA advised that that *'the severity of [the patient's] condition was not identified or communicated'* to the Duty Control Officer, which contributed to the delay in the ECV. In addition, the DCM IPA advised that the paramedic had *'no sense of urgency'* when the Duty Control Officer stated that he could not give him an estimated time of arrival for the ECV.

105. I refer to EAC SOP, Section 30.3, which states '*RRV Responders, as with staff generally, carry personal responsibility for ensuring that they work to the best of their abilities without casual mistakes… Personnel are expected to keep themselves up to date with best practice and to maintain service quality.'*

Based on all available evidence, I conclude that the control room was already aware of the severity of the patient's condition. I note the caller in the initial 999 call advised that the patient was having *a 'cerebral attack',* and the EMD had coded the call as *'Category 'A' Red'.* In addition, as the paramedic was on scene with the patient, I consider that it was important for him to remain calm and professional in a highly pressurised environment.

106. However, as noted previously in this report, a full telephone FAST assessment could not be performed on the initial 999 call, as the patient was not fully alert. Therefore, I accept the DCM IPA's advice that the paramedic ought to have advised the Duty Control Officer that the patient was FAST positive. I consider this a failing in the patient's care and treatment. As a result of this failure, I consider that he suffered the injustice of distress and loss of opportunity to be assessed by the ECV sooner with the consequential long term health impact. I will consider if this failure had an impact on The Duty Control Officer's decision in relation to the allocation of an ECV in paragraphs 109 to 121. I also consider that the complainant suffered the injustice of uncertainty in relation to the failure in his father's care and treatment.

107. As noted above, I understand that NIAS provided feedback to the paramedic and provided him with additional training. I also note the NIAS acknowledged that a quicker request *'may have aided'* the patient's long term health (see '*Effect of delays on The patient's health and wellbeing'*).

Decision to withhold the ECV for Belfast/ Lisburn Area

108. In response to enquiries, I note the NIAS confirmed that the paramedic requested an ECV at 11.25, an ECV (E222) was dispatched at 12.09hrs, and it arrived on scene at 12.46hrs.

109. I note the NIAS stated that at the time of the paramedic's request for an ECV, only one ECV was providing cover for Belfast, Lisburn, and North and South Down Areas. I note the NIAS explained that three emergency day crews had been scheduled for the Newcastle and Downpatrick areas, but due to staff shortages only one crew was available. As a result, I note the NIAS stated

that The Duty Control Officer made the decision to hold ECV to provide cover for the Belfast/ Lisburn areas, including the East City and East Country Divisions given *'the potential for an immediately life threatening call in the Greater Belfast area.'* I note the NIAS explained that an influential factor in making this decision was the fact that the patient had a paramedic present with him.

110. In addition, in relation to the allocation of resources, I note the NIAS stated that it uses *'predictive analysis for status planning.'* When predicting the location of the next emergency call, I note the NIAS stated that the Belfast/ Lisburn areas appear higher on the Status Planning Management System in comparison to the Downpatrick/ Ballynahinch areas, *'based on patterns of demand in the past.'*

111. However, I note the DCM IPA advised that the decision made by the Duty Control Officer *'was not a reasonable one and was an un-safe decision.'* The NIAS have accepted that the Duty Control Officer's decision *'was not best practice.'* As referenced above, although the paramedic did not advise the Duty Control Officer that the patient was FAST positive, the DCM IPA advised that the patient's symptoms as described in the 999 call were '*obvious stroke symptoms which are time critical due to the potential for thrombolysis treatment.'* I refer to the NIAS' Timescale Memo, which states *'any patient presenting within four and a half hours of the onset of [acute stroke] symptoms may now be considered for thrombolysis treatment in hospital… [and] must be regarded as a time critical emergency.'* I refer to the EAC SOP, Section 6, which states that *'no patients are to be unnecessarily kept waiting. If there is an appropriate resource available they should be deployed.'*

112. In addition, I note the DCM IPA advised that although the Duty Control Officer *'assumed that the Paramedic and off duty doctor were adequate when withholding E723… neither medics… were able to offer any more than comfort and observations whilst awaiting transportation to hospital.'* I refer to Section 6.1 of the EAC SOP, which states that '*It is the Control Officer's responsibility, based on the category and type of call, to assign and ensure that the most appropriate resource is dispatched to the incident.'* I also refer to

EAC SOP, Section 30.3, which states '*Personnel are expected to keep themselves up to date with best practice and to maintain service quality.'*

113. On review of the available evidence, I consider that on the balance of probabilities, the paramedic's failure to advise that the patient was FAST positive, would not have altered the Duty Control Officer's decision making in this instance. This is due to the fact that the Duty Control Officer was aware that the patient was suffering from stroke symptoms as detailed in the initial 999 call, there would still have been only one ambulance providing cover for the Belfast/ Lisburn/ East City and East Country Division areas, and a paramedic was present with the patient.

114. In addition, I accept the DCM IPA's advice that the Duty Control Officer's decision to withhold [E1] was unreasonable. As per the DCM IPA's advice and the NIAS' Timescale Memo, I consider that the patient's symptoms of possible acute stroke made him *'a time-critical emergency'* for thrombolysis treatment. I consider the failure of the Duty Control Officer to send the ECV constitutes a failure in the patient's care and treatment. I consider this failure resulted in the patient suffering the injustice of distress and loss of opportunity to have appropriate care at a significant time in relation to his condition. I also consider that the complainant suffered the injustice of uncertainty in relation to the failure in his father's care and treatment. I am pleased to note that the NIAS has apologised to the complainant for the Duty Control Officer's *'flawed decision'.*

115. I note the DCM IPA also advised that '*some of the responsibility [for not sending [E1]] should… lie with the Duty Control Manager as his role is to manage and supervise the call centre, support staff and monitor delays.'* On review, I note the DCM IPA advised that he *'had not reviewed [the patient's] call record',* and only became aware of the ECV delay following a phone call from the complainant. As a result, the DCM IPA advised that it appears that he *'did not have a clear oversight of the shift he was managing'* and *'the Dispatcher [DCO] had no support attempting to manage the delayed responses.'*

116. In relation to the DCM's role, I note the DCM IPA advised that it involves *'liasing with the control officers when resources are scarce and support[ing] decisions for [the] correct allocation of resources.'* I note the DCM IPA advised that the Duty Control Officer and were *'reminded'* of the need to maintain professionalism, *'with no further action'.*

117. I accept the DCM IPA's advice that the Duty Control Manager did not have an adequate oversight of the delay and therefore did not provide him with the support he required to manage resources. I consider this failure constitutes a failure in the patient's care and treatment. As a result, I consider this failure resulted in the patient suffering the injustice of distress and loss of opportunity. I also consider that the complainant suffered the injustice of uncertainty in relation to the failure in his father's care and treatment.

118. I note the NIAS stated that an IO discussed the importance of balancing the provision of cover and the allocation of resources with The Duty Control Officer. However, in response, I note that The Duty Control Officer stated that *'I can assure you I have been spoken to by no-one within NIAS about this call, other than the on duty DCM.'*

119. In addition, I note the NIAS has stated that it is using this case *'as part of a case study review at Post proficiency of CPD training'.*

120. Subsequently, at 11.31hrs, I note the NIAS stated that a second ECV cleared at the RVH, and its intention was to dispatch this vehicle to the patient. However, due to the nature of the previous call, this ECV required cleaning and restocking. As a result this ECV was not dispatched for a further 38 minutes. I note the Duty Control Officer stated that it was dispatched following cleaning, as *'it was 12 – 15 minutes closer to Ardglass'.*

Effect of delays on the patient's health and wellbeing

121. As part of investigation enquiries, the C IPA was asked what effect the delays identified above had on the patient's health and wellbeing. I note the C IPA advised on review of the patient's medical records he *'would have been a*

candidate for thrombolysis.' As a result, the C IPA advised that *'the delays caused by [the NIAS] potentially contributed to adverse patient outcomes.'*

122. In relation to thrombolysis treatment, I note the C IPA advised that although *'most centres do not have an upper limit of age for treatment',* but some clinicians are of the opinion that thrombolytic therapy in the elderly is less effective and safe. I note the C IPA advised that *'the difference in risk with lysis in the elderly has been subject to variable estimates from no difference to an approximately 5% greater risk of intracranial haemorrhage.'* However, I note the C IPA advised that '*age alone should not be a barrier to treatment.'* I refer to the letter sent to the complainant on 29 March 2017, which confirmed that '*Whilst our current protocol continues to have an upper age limit of 80yrs, we do lose patients above this age on an individualised basis.'* Therefore, on consideration, the patient's age would not have been a barrier to his receiving of treatment.

123. I also note the letter stated that the patient '*had arisen from bed to toilet on 10/12/2016 [10 December 2016] at 08.15 and had fallen off the toilet. The clinical concern was that his fall had occurred on the basis of an acute stroke which either occurred at this time or possibly was present when he awakened from his sleep… I viewed your father's onset time as 08.15.'* In addition, the patient's discharge letter from Ulster Hospital stated that he '*was probably a wake up stroke.'*

124. I note the C IPA advised that *'time is critical… with the best outcomes occurring within the first 90 minutes and decreasing thereafter'.* I note the C IPA advised that for '*eligible patients, treatment with thrombolysis for acute stroke within three hours of symptom onset leads to a 16% reduction in unfavourable outcomes as measured by the modified Rankin score.'* If the patient is treated between three and four and a half hours, I note the C IPA advised that *'the effect is less powerful'*, with a *'reduction in disability of approximately 7%.'* Outside of these timeframes, the C IPA advised that treatment is not deemed effective. I note the C IPA advised that these timeframes are acknowledged by NICE Guidelines on strokes, which

recommend that *'"treatment is started as early as possible" once haemorrhage is excluded up to a time window of 4.5 hours after the onset of symptoms.'*

125. In order for the patient to receive treatment, I note the C IPA advised that *'he would have [had] to arrive at hospital by mid-day'* if the time of his stroke was *'perceived as 08.15'.* The C IPA advised that this was due to the fact that the time taken to assess The patient at the hospital, check the INR and report a CT scan *'appears to be about 45 minutes'.* I note the C IPA advised that '*If a reasonable ambulance response, assessment and transfer to hospital would have taken 90 minutes then… clinical outcomes would not have altered and although the service was extremely poor, the outcome ultimately was not changed.'* However, I note the C IPA advised that if *'the ambulance would have arrived at hospital before 12.00 without the delays incurred, then the patient has been unreasonably denied the small possible benefit of lytic therapy.'*

126. I refer to the NIAS' Thrombectomy Memo, which states that between Monday and Friday, and 08.00hrs and 17.30hrs, a patient who has *'developed symptoms of acute CVA within the past twelve hours, and who are FAST-positive… must still be brought to the nearest hospital offering a 24/7 stroke service for initial assessment.'* However, the patient took ill on a Saturday. The NIAS' Thrombectomy Memo states that *'at all other times, all patients who present with the symptoms of an acute CVA within the previous four and a half hours, and who are FAST positive… must be brought to the nearest hospital offering a 24/7 stroke service.'*

127. Overall, I note the C IPA advised that *'if an undelayed ambulance would have arrived at hospital before 12.00, then the delays in transport of [the patient] to hospital potentially reduced the chances of disability reduction.'* I note the C IPA advised that *'theoretically the patient would have presented in the 3-4.5 hour time window with more prompt transfer… then it seems likely that there was a denial of an approximately 5% chance of disability reduction.'* However, I note the C IPA also advised that *'if with the required paramedic time on the*

scene and transfer to hospital promptly, then the patient would still have arrived after 12.00, then although the delays have been distressing, the outcome has not been greatly affected.'

128. I have established that it the RRV had been dispatched within the eight minute target response time, it would have arrived on scene at 10.37hrs. I accept the P IPA's advice that the paramedic's assessment of the patient on scene was reasonable. Therefore, it is likely that an ECV would not have been requested by the paramedic until 11.04hrs. As per the DCM IPA's advice, [E1] cleared at Belfast Victoria Hospital at 10.55hrs, and was requested to return to Lagan Valley to provide cover. If it was available to dispatch immediately from Lagan Valley at 11.04hrs, it would have required a travel time of approximately 50 minutes[8]. As a result, it may have arrived with the patient at approximately 11.34hrs.

129. I note that the ECV was on scene with the patient from 22 minutes before departing, and it had a travel time of 53 minutes to the hospital. Therefore, it is likely that the patient would have arrived at hospital at approximately 12.49hrs. I note the C IPA also advised that the assessment of the patient at hospital, to check the INR and report a CT scan, took *'about 45 minutes'.*

130. Therefore, on the balance of probabilities, I consider that it is unlikely that the patient would have arrived at hospital within the timeframe to receive thrombolysis. I agree with the C IPA's advice that the delays experienced by the patient were distressing. However, on consideration of the available evidence it is unlikely that the patient's outcome would have been greatly affected.

131. I am pleased to note the NIAS stated that '*through the adoption of the new Clinical Response Model, NIAS is hoping not only to improve response times in general to patients of all categories, but also to specifically ensure that a conveying resource arrives more rapidly in those situations where one is likely*

[8] Google Maps estimates a travel time of approximately 52 minutes from Lagan Valley, Lisburn to the patient's home address. However, as this route includes 'B' class roads, and including the possibility of traffic, the journey time may have been longer.

to be necessary… It is the intention of NIAS to make the necessary changes to our response code set in the near future.'

CONCLUSION

132. I have investigated the complaint and have found a failure of care and treatment provided by the NIAS in the following matters:

(i) Failure of the RRV to respond to a Category 'A' Red call within eight minutes

(ii) Failure of the paramedic to advise the Duty Control Officer that the patient was FAST positive when requesting an ECV

(iii) Failure of the Duty Control Officer to immediately send ECV [1] to the patient upon receipt of the paramedic's request

(iv) Failure of the Duty Control Manager to have an adequate oversight of the ECV's delay when responding to the patient

133. As a result of the failures in care and treatment, I am satisfied that the patient suffered the injustice of distress, and the loss of opportunity to be assessed by the RRV Paramedic and ECV crew sooner. In this case, the complainant complained on behalf of his father as a person aggrieved. However, I consider that he also is a person aggrieved. As a result of the failings in his father's care and treatment, I am satisfied he suffered uncertainty.

Recommendations

134. I recommend that the NIAS issues the patient with an apology in accordance with the NIPSO guidance for the injustice identified in this report. I recommend the NIAS issues the complainant with an apology in respect of the injustice I have identified, namely uncertainty. Both apologies must be issued **within one month** of the date of my final report.

135. I also recommend the NIAS makes a payment of £750 to the patient by way of solatium in respect of the injustice I have identified, namely loss of opportunity and distress, **within one month** of the date of my final report.

136. I consider there were a number of lessons to be learned by the NIAS which provides it with an opportunity to improve its services, and to this end, as per the DCM IPA's advice, I recommend the NIAS updates its EOC Standard Operating Procedure, Section 30 – RRV Deployment, issued April 2014, to:

(i) Include a dual response (if the RRV is deployed first) to patients experiencing Stroke and Cardiac Symptoms;

(ii) Ensure attending clinicians confirm that an ambulance back-up is required as soon as time critical incidents are identified;

(iii) Include a clinical oversight to review calls waiting for back up within the dispatch queue.

137. I recommend that the NIAS discusses the importances of balancing the provision of cover and the allocation of resources with the Duty Control Officer.

138. I also recommend that the NIAS shares the learning experiences of the paramedic, the Duty Control Officer and the Duty Control Manager as case studies, and provides guidance to:

(i) RRV Paramedics on identifying FAST positive patients, highlighting the need to urgently request ECVs for patients who are FAST positive;

(ii) DCOs in relation to the allocation of resources, detailing that withholding a resource for cover is an unsafe practice;

(iii) DCMs in relation to keeping oversight, managing delays, and allocating resources appropriately;

(iv) The above staff on thrombolysis treatment, highlighting the importance of timing.

139. I note that the NIAS stated that it is in the process of preparing to undertake a public consultation on its proposals to improve response times, levels of cover and quality of care to patients, including its proposed Clinical Response

Model. In addition, the NIAS stated that it is engaging in a recruitment and training program to reduce reliance on overtime and to ensure staff comply with planned hours. I recommend that the NIAS provides evidence of the progression of this activity **within three months** of the date of my final report.

140. I recommend the NIAS develops an action plan which outlines the steps considered in implementing my recommendations, and provides me with an update **within three months** of the date of the final report. The action plan is to be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/ or self declaration forms which indicate that staff have read and understood any relevant policies).

PAUL MCFADDEN
Deputy Ombudsman **January 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.