Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Northern Ireland Ambulance Service Trust

NIPSO Reference: 19282

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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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SUMMARY

I received a complaint about the care and treatment provided to the complaint and her son by paramedics following his home birth on 10 March 2018.

The complainant said that she and her son were made to travel to the hospital in separate ambulances. She also complained about how her son was transported in the ambulance, which she believed led to him contracting an infection.

The investigation established that the midwives in attendance had primacy in deciding whether or not the baby would travel with his mother to the hospital. The South Eastern Health and Social Care Trust also accepted that the decision lay with the midwives as the specialists in that particular situation. Therefore, it was considered there was no failure by NIAST by transporting the baby separately to hospital. Furthermore, I was unable to conclude whether or not the actions of the paramedic who held him in the ambulance caused him to contract an infection.

The investigation of the complaint established that the paramedics failed to record their assessment of appropriate equipment to use when transporting the baby in the ambulance. It also established that the paramedics failed to report an untoward incident regarding the lack of appropriate equipment available to transport a new-born infant in the ambulance, and that the NIAST failed to provide appropriate guidance to its staff on methods of transport for new-born infants in ambulances. The investigation further established that the paramedics failed to take and record appropriate medical observations during the journey to hospital.

The investigation also established failings in how the NIAST managed the complaint.

I recommended that the NIAST ought to apologise to the complainant for the failures identified. I also made recommendations in relation to improving the service provided by the NIAST. I welcome that the NIAST's Medical Equipment Group are considering suitable equipment available for transporting new-born infants in ambulances.

THE COMPLAINT

Background to complaint

1. The complainant delivered her son at 01:00 on 10 March 2018 in a planned home delivery. Present at the birth were two community midwives and a student midwife. Following birth, the midwives assessed that he had no respiratory effort. One of the midwives in attendance gave him four sets of inflation breaths[1]. An ambulance was requested at 01:04. At this stage, respiratory effort was present and both his colour and tone had improved. The records document that the complainant delivered the placenta at 01:25.

2. The paramedics arrived on scene at approximately 01:25. Upon arrival, a decision was made not to transport the complainant along with her son in the ambulance. The ambulance left with the baby at 01:47 and arrived at the Ulster Hospital at 01:58. A second ambulance was requested to transport the baby to hospital at 01:28. It arrived at the Ulster Hospital at 02:28.

3. He was admitted to the Ulster Hospital upon his arrival. During his stay, he was treated for early onset of sepsis[2]. He was discharged from hospital to home on 12 March 2018.

4. The complainant made a complaint about the decision to transport her and her son to the hospital in separate ambulances. She also complained about the method the paramedics used to transport him in the ambulance, stating that this led to him contracting an infection. She further complained about the NIAST's handling of her complaint.

Issue of complaint

5. The issues of complaint accepted for investigation were:

   Issue 1: Whether the complainant's son was transferred to hospital by the NIAST in accordance with policy, guidelines and appropriate standards?

[1] Used in newborn resuscitation, to facilitate the aeration of the fluid-filled lungs, by applying a higher airway pressure for a prolonged period of time.
[2] A condition that arises when the body's response to infection causes injury to its own tissues and organs.

Issue 2: Whether the NIAST's handling of the complaint was in accordance with NIAST policy and appropriate standards?

INVESTIGATION METHODOLOGY

6. In order to investigate the complaint, the Investigating Officer obtained from the NIAST all relevant documentation together with the Trust's comments on the issues raised. The Investigating Officer conducted interviews with the ambulance crew who attended the baby, and the complainant.

Independent Professional Advice

7. After consideration of the issues, I obtained independent professional advice from the following professional advisor:

- A Registered Allied Health professional and Paramedic; 30 years' experience of working within NHS Ambulance Trusts in both front line clinical and operational managerial roles (P IPA).

8. The information and advice which have informed my findings and conclusions are included within the body of my report. The P IPA 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

9. 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.

The general standards are the Ombudsman's Principles[3]:

- The Principles of Good Administration
- The Principles of Good Complaint Handling

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The Public Services Ombudsmen Principles for Remedy

10. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgment of the NIAST staff whose actions are the subject of this complaint.

11. The specific standards relevant to this complaint are:
    - Facilitating Maternity Transfers in the South Eastern Trust – an internal memo provided by the Assistant Medical Director for the Northern Ireland Ambulance Service Trust, October 2013 (the NIAST Memo);
    - The Health and Care Professions Council's (HCPC) Standards of Proficiency for Paramedics, September 2014 (the HCPC Standards of Proficiency);
    - The Health and Care Professions Council's (HCPC) Standards of Conduct, Performance and Ethics, January 2016 (the HCPC Standards of Conduct);
    - The Northern Ireland Ambulance Service Trust's Untoward Incident Reporting and Management Policy, November 2014 (the NIAST's Untoward Incident Policy);
    - The Northern Ireland Ambulance Service Trust's Complaints Policy, April 2015 (the NIAST Complaints Policy); and
    - The Department of Health's (DoH) Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning, April 2009 (the DoH Complaints Procedure).

12. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

13. A draft copy of this report was shared with the complainant and the NIAST for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the complainant was transferred to hospital by the NIAS in accordance with policy, guidelines and appropriate standards?

14. The complainant said that following the birth of her son on 10 March 2018, paramedics would not permit her to travel with her son in the same ambulance. She complained that the paramedic was '*unsure of the protocol'* and had '*never attended a situation like this'*. She stated that the midwives present informed the paramedic that normal procedure was for the mother and baby to travel together, but the paramedic said that they could not travel together and would require a separate ambulance. She explained that this caused her stress and anxiety.

15. She also complained that the paramedic held her baby in his arms in the rear of the ambulance during transport. She explained that this caused her upset. She believed that this method of transport caused him to contract an infection. She explained that he would have had contact with his uniform, which would have been exposed to other ill patients in his role as a paramedic.

Evidence Considered

Legislation/Policies/Guidance

16. I refer to the following legislation, policies and guidance which were considered as part of investigation enquiries:

    i. I considered the NIAST memo and identified the following extracts:

    '*With the development of Midwifery Led Units*[4] *(MLUs) in Northern Ireland, NIAS is receiving an increased number of requests for both emergency and non-emergency transfers of expectant and recently-delivered mothers and their babies between hospital sites. On some occasions, crews have declined to transport newborn babies along with their mother due to*

[4] A unit where all care is carried out by midwives.

concern about use of child restraints and the risk associated with emergency journeys etc.

Following a meeting with the senior staff of the South Eastern Trust Maternity Service, it has been agreed that:

- *MLU staff will assess the clinical requirement for a baby to travel with their mother in an ambulance taking into account the small but inevitable risk associated with blue-light transfers[5], and will therefore assume responsibility for this risk assessment. NIAS crews will accept the primacy of this decision by the hospital clinical staff and will therefore transport appropriately restrained babies when requested to do so by the MLU staff.*
- *MLU staff in the South Eastern Trust have all been trained in the fitting and use of an appropriate child restraint system to be used for the baby during these journeys, and will fit this into a forward-facing seat in the ambulance, securing it with a three-point harness. NIAS has already assessed this restraint as suitable for use in our vehicles as long as it is fitted as described. The MLU staff will assume responsibility for checking that the baby is appropriately secured in the restraint and that the restraint itself is properly secured via the seat belt, although NIAS crews must ensure that the seat belt is correctly locked as the driver has ultimate responsibility to ensure the safety of passengers'*.

ii. I considered the HCPC Standards of Proficiency for Paramedics and identified the following relevant extracts:

'[Standard 10] Be able to maintain records appropriately

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines

[Standard 14] Be able to draw on appropriate knowledge and skills to inform practice…

[5] In emergency situations.

14.7 know how to select or modify approaches to meet the needs of patients, their relatives and carers, when presented in the emergency and urgent care environment
14.8 be able to formulate specific and appropriate management plans including the setting of timescales…
14.14 understand the need to consider the assessment of both the health and psycho-social care needs of patients and carers'.

iii. I considered the HCPC Standards of Conduct and identified the following relevant extracts:
'[Standard 1] Promote and protect the interests of service users and carers…
1.2 You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided…
[Standard 2] Communicate appropriately and effectively…
2.2 You must listen to service users and carers and take account of their needs and wishes…
Work with colleagues
2.5 You must work in partnership with colleagues, sharing your skills, knowledge and experience where appropriate, for the benefit of service users and carers…
[Standard 10] Keep records of your work
Keep accurate records
10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to'.

iv. I considered the NIAST's Untoward Incident Reporting policy and identified the following relevant extracts:
'4.0 Policy Statement(s)
4.1 The NIAS Health and Social Care Trust is committed to providing the best possible services for patients, clients, visitors and staff. The Trust recognises that Untoward Incidents will occur and that it is important to identify causes to ensure lessons are learned to prevent reoccurrence…

4.6 All staff must report and manage Untoward Incidents according to this policy and related procedures for Untoward Incident reporting (see section 6.8.) Staff who make a prompt and honest report in relation to an Untoward Incident or near miss will not be disciplined with the exception of the following circumstances:

- *A breach of law;*
- *Wilful or gross carelessness or professional misconduct;*
- *Repeated breaches of Trust policy and procedure;*
- *Where, in the view of the Trust, and/or any professional registration body, the action causing the Untoward Incident is far removed from acceptable practice;*
- *Where there is failure to report a major or catastrophic Untoward Incident in which a member of staff was involved or about which they were aware…*

5.2 Untoward Incident:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation." (How to Classify Untoward Incidents and Risk, HPSS April 2006)…

6.8 All Staff:

All Trust employees have a responsibility to:

- *ensure individuals involved (patients, clients, contractors, visitors or staff) and the environment / equipment, are made safe…;*
- *ensure the appropriate line manager/Head of Department is informed;*
- *report Untoward Incidents by completing the Trust Untoward Incident report form (electronic or paper) and forward to their line manager / supervisor / person in charge and the Risk Manager…'*

The NIAST's response to investigation enquiries

17. In response to investigation enquiries, the NIAST explained that '*it is our understanding that the baby was transported by the crew as soon as the crew arrived at scene, I am informed that the baby required rescue breaths following*

delivery and therefore immediate transport was required'. It also explained that '*it is our understanding that the need for immediate transport was due to the period of apnoea[6] along with the potential delay as the mother had not delivered the placenta at the time the crew were ready to leave'*.

18. The NIAST explained that '*the only child restraints on an A&E [accident and emergency] vehicles are the fold down child seat and restraining straps at the captain's chair[7] and the Pedi-Mate[8] restraining device which attaches to the stretcher. Neither of these devices are suitable for a new born baby'*. The NIAST was asked if the ambulance crew considered using the baby's infant carrier to aid transport of him in the vehicle. The NIAST explained that '*the crew have stated they did not use the family's own infant car seat as they thought it would not be appropriate on this occasion. Paramedic…carried the infant in his own arms which enabled him to provide supplemental oxygen[9] via an O2 [oxygen] tube near the child's mouth and nose whilst at the same time being able to observe and assess the child for appearance, work of breathing and circulation (skin colour and temperature and capillary refill[10]). If the child had been in a car seat strapped into the captain's chair then he would not have been able to observe or provide the appropriate care'*.

19. In relation to the complaint that the method the paramedic used to transport the baby to hospital led to him contracting an infection, the NIAST explained that *'the investigating officer was informed at the time by the midwife who was at scene that infection markers[11] were only slightly raised and in no way definitively indicating the presence of an infection'.*

20. The NIAST explained that '*NIAS accepts that this was a difficult and distressing situation for [the complainant] to have to travel separately from her newly born baby and for this we apologise'*. In relation to learning identified, the NIAST explained that the '*investigating officer for this complaint has identified that the*

[6] Temporary cessation of breathing.
[7] A visual focal point in the ambulance module. It is designed to keep personnel seated and restrained while providing care.
[8] Method of safe transport for children ranging in size from 10 to 40lb.
[9] The use of oxygen as a medical treatment.
[10] The time taken for colour to return after pressure is applied.
[11] Outcome of tests taken to indicate an infection.

ambulance staff should have documented the name of the midwife and the instructions that the midwife issued onto the relevant patient report form[12] *(PRF). [It was] also highlighted the importance of clear communication for all parties during such incidents…these learning points need to be actioned and brought to the attention of the relevant NIAS staff*'.

Interviews

Interview with Paramedic 1

21. As part of the investigation, the Investigating Officer interviewed Paramedic 1. He explained that he and Paramedic 2 were the paramedics who responded to the first call made at 01:04. He also explained that he was the '*attendant*', as he had '*direct dealings with the patient'*.

22. Paramedic 1 explained that the '*midwives being the experts, we take our lead from them. It became clear from the way the midwife was talking that the initial emergency, i.e. child not breathing, had passed but he's still a sick child as far as we're concerned and he was the one that we were there for'*. He further explained that '*it was made clear to us that unfortunately [the complainant] was still in the process of delivering her placenta and that was going to take time, you can't put a time on it. It could've been five minutes after we left or it could have been half an hour there, we didn't know. The main priority as I said before was [the baby] and as a result they were transported separately'*. Paramedic 1 was asked if there was a discussion with the midwives about the decision for mother and child to travel separately. He explained, '*I don't recall it being discussed at any stage'.* Paramedic 1 was also asked if the decision to travel separately was made by the midwives. He explained that '*I do not recall full details. But I would imagine it would have been a joint thing'*.

23. In relation to the method used to transport the baby to hospital, Paramedic 1 explained that '*he babyt was not breathing whenever he was born…so [he] had to be observed closely…should he stop breathing again or should there be no signs of life it is imperative that you get started CPR [cardiopulmonary*

[12] The form completed by the attending ambulance crew.

resuscitation[13]] as soon as possible. So the usual method of transporting a normal birth is for the mother to hold the baby…the mother goes on [the] trolley and it's moved. In this case obviously mother is not going so the next option then is for me, as I was the attendant, to hold the baby and to observe'.

24. When asked if he considered any other method of transport for the baby, Paramedic 1 explained, *'you always do…but very quickly it would be eliminated for various reasons. The main reason in this case was we felt, I felt, that observation of [the baby] was the priority.* Paramedic 1 further explained that '*there was oxygen put in…the general area so that area would be oxygen enriched without actually blowing on his face…and observed by me constantly throughout'.*

25. Paramedic 1 was asked if he considered using the baby's infant carrier as a method of transport in the ambulance. He explained, *'I wasn't aware of that at the time but…even at that, that wouldn't allow me to observe. Most infant carriers are set in such a position on chairs, in ambulances, and indeed in cars, that it's awkward to see the child. And that's probably why they still use the mother holding type thing…so as I say we would go through the things very quickly and that would've been eliminated quite quickly because I need to observe this boy'.*

Interview with Paramedic 2

26. As part of the investigation, the Investigating Officer also interviewed Paramedic 2. He explained that he is a '*Medical Emergency Technician'*. He further explained, '*we tend to…rotate on our duties, i.e. I will drive one shift and he [Paramedic 1] will drive the next. On this particular occasion it was Paramedic 1's turn to drive and my turn to attend, but when we received the call the nature of the call from memory being, relating to a baby not responding at birth, we quickly decided that he as the Paramedic is, as a more professional and skilled person, should actually attend when we arrived at the scene… he was responsible for the care of the patient*'.

[13] An emergency procedure that combines chest compressions often with artificial ventilation in an effort to manually preserve intact brain function.

27. In relation to the decision for the complainant and the baby to travel to the hospital in separate ambulances, Paramedic 2 explained, *'my understanding is that, and our primary concern as a crew, was for the welfare of the child, that's the way the call had been given out and that's why we had responded…the priority as given to us by the midwives in attendance, and the obvious scene when we arrived, was the child who reportedly had not been breathing at birth, for him to be rapidly taken to the nearest treatment centre to be assessed. And that was our priority. So the midwives present, or the midwife I was talking to anyway seemed to be on the same hymn sheet as us in that regard. And my memory is that the mother still hadn't delivered the placenta'.* He further explained that the midwives were '*taking care of the mother and in agreement with the midwife our role was to take the child to the Ulster [Hospital] as soon as possible'.*

28. Paramedic 2 explained, '*we, as a crew, engage with the midwives so what I actually said or what Paramedic 1 said I wouldn't be able to recall directly*'. When asked if there was any record taken of a discussion with the midwives, Paramedic 2 explained, '*certainly not by us but possibly by the midwife. The midwife was drawing up notes in our presence and before we left the scene, what was in those notes, I was personally of the opinion that they related specifically to the medical condition of the child and the circumstances. I don't recall her saying anything about a discussion on the method of transfer or anything else'*.

29. When asked about the responsibility for making the decision for the complainant and the baby to travel separately, Paramedic 2 explained, '*when other healthcare professionals are present, already present at the scene, especially midwives in that sort of situation, they take the lead, that's quite clearly the necessity and the role'*.

30. In relation to the method used to transport the baby in the ambulance, Paramedic 2 explained that *'these are difficult situations for us as ambulance staff, they are not everyday situations. There are not clear protocols for this particular scenario. Most of the protocols we adhere to would be for enter hospital type arrangements [sic] where there are quite clearly facilities and*

equipment available for this sort of scenario. Anything that we carry on an ambulance per se is only suitable for children of a certain age, certainly not for new born children and therefore in my mind the only options would be a seat that the child has of its own…provided by the parents. But under these circumstances I would have thought…not only unnecessary but inapplicable in that I would've done the same as Paramedic 1 did, I would've been holding the child close to me for observation, for free flow of oxygen. Those were the only things that we could do. And to have a child strapped, who could potentially stop breathing again, to have a child strapped in some kind of a harness that we are untrained on, unfamiliar with, have to maybe try and withdraw him at speed from that particular piece of equipment, which we are not au fait with, there could be a buckle on it, it's unavailable for us to use, all of that doesn't make any practical sense from our, or from my perspective. So as regards what Paramedic 1 did I would do exactly the same, and would've done exactly the same…the onus was to keep the child as close, as close as possible with the availability of free flow oxygen'.

Relevant records

31. The complainant's and the baby's clinical records provided by the NIAST were carefully considered.

32. The records documenting the events on 9 and 10 March 2018 were considered. The maternity records document that the baby was born at 01:00. They also document that the complainant delivered the placenta at 01:25.

33. The maternity records document, '*parents informed of need to transfer baby to Ulster Hospital for observation. Paramedics arrived at approximately 01:25. SBAR[14] [situation, background and recommendation] by [midwife] to ambulance crew. [Midwife] contacted Ulster Hospital neonatal unit and liaised with paed [paediatric] nurse…re baby's transfer to unit (at 01:45 approx). Mum made comfortable. Paramedic wrapped baby in a blanket and left parental home at 01:45 approx'*.

[14] A structured form of communication that enables information to be transferred accurately between healthcare professionals.

34. The maternity records document, '*call received from SR [Sister]…situation explained and debriefed. Advised that mum to be transferred to home from home. Second ambulance requested and arrived at approx. 02:00 hrs. Mum transferred to unit care. Handed over…at 02:30 hrs*'.

35. The NIAST provided the completed patient report form (PRF) for both the complainant and the baby's journey to the hospital. The PRF for the baby states, '*call from midwives for child (home birth) not responsive at birth. Rescue breaths from midwives. [Unclear] was breathing normally and appeared healthy. Midwife not available to travel in ambulance so baby dressed with blanket for heat. Free flow O2 @ 4 lts [litres] as precaution on route. No obs [observations] possible'*.

36. The NIAST also provided recordings of the two emergency calls made by the midwives in attendance at the baby's home birth. The first call was made at 01:04 by the student midwife. The student midwife informed the call handler that the baby was '*not overly responding'*. She also reported that the baby was awake and his heart rate was '*fine*'.

37. The second call was made by the student midwife at 01:28. She informed the call handler that the ambulance had arrived but a second was required to transport the mother to hospital. The student midwife explained that the ambulance crew had not left. She also stated, '*they've said the mum can't go in the same one'*. She also informed the call handler that the '*placenta has also been delivered'*.

38. The clinical records relating to the baby's stay in hospital following his birth were provided. The records document that his C reactive protein[15] (CRP) level was 7.5 on 11 March 2018 at 10:50. The baby's CRP rose to 13.1 at 22:40 the same day and he was treated with antibiotics (intravenously[16]). The records document that the baby's CRP level fell to 9.8 at 08:15 on 12 March 2018. He was discharged to home the same day.

[15] Inflammation in your body increases the level of C-reactive protein in your blood, possibly indicating an infection or other condition.
[16] A therapy that delivers fluids directly into a vein.

39. The NIAST provided a note of a telephone call it had with the complainant following the submission of her complaint. The note documents, '*complainant was very upset at the treatment she received by the driver of the emergency ambulance. Her concern is another mother being treated the same, as his attitude was appalling and the complainant felt as though the call was a hassle for him in particular'*.

40. The NIAST provided a note of a telephone call it had with one of the midwives in attendance with the complainant during the birth of her son. The note documents, '*following the telephone discussion with the complainant, contact was made with the midwife who was in attendance at the complainant's home birth. She was very clear that the ambulance crew acted appropriately and in accordance with her wishes. She stressed that at the time they arrived, the mother had not delivered her placenta and therefore could not have travelled in the ambulance. As the child had a period of apnoea at birth she would not have wished for any delay in the transfer to hospital. The midwife also questioned the mother's concern regarding the infection, she remembers markers were only slightly raised and the infection risk was high due to the environment of the birth. Therefore it would be difficult to direct blame [at] the ambulance crew as the source of the infection'*.

41. The NIAST spoke with the complainant following its correspondence with the midwife. The note of the call documents, '*the discussion with the midwife was relayed and I explained the ambulance crew would be expected to follow the guidance of a specialist at scene, in this case the midwife. I informed [the complainant] of a meeting with the crew where we discussed communication and how it may have failed in this case and the risk of making assumptions when other healthcare professionals are at scene. [She] accepted our position although she disputed the time frames, she recognised the issue is now with the midwife unit. [She] recognises it is not my place to question the midwife and she plans to pursue them herself'*.

Additional information received

Information from the South Eastern Health and Social Care Trust (SEHCT)

42. The midwives that attended the complainant's home birth were employed by the SEHSCT. The SEHSCT explained that it received a complaint about the actions of the midwives following the baby's birth. The complaint was dated 12 June 2018.

43. In its response, the SEHSCT explained that '*the midwife is the lead professional and following communication with the ambulance team, the midwife makes the decision'.* The SEHSCT also explained that '*you should have both travelled together to the Ulster Hospital Maternity Unit. I apologise that this was not the case and you were separated from your son at a very difficult time'*.

Relevant Independent Professional Advice

44. As part of investigation enquiries, the advice of an independent paramedic was obtained (P IPA). In relation to the decision for the complainant and the baby to travel in separate ambulances, the P IPA advised that '*it is not possible from the information contained within the file to determine who made the decision that [the complainant] and the baby should not travel together in the ambulance. No written record has been made of the discussion/decision by the paramedic on the patient report form'*. The P IPA further advised that the responsibility for making this decision '*should have been taken by the midwives (as they are the specialists in the field of obstetrics) and this is clearly identified in the internal memo…entitled Facilitating Maternity Transfers in the South Eastern Trust'*. She added that '*in the absence of any policy or in the event an ambulance crew are unsure of protocol or policy, the midwife should be considered to have supremacy as the 'specialist', but it is common and routine practice for crews to discuss options with the midwife, patient and relatives if circumstances allow, before a plan is made that is suitable and beneficial to all'*.

45. In relation as to whether the paramedics ought to have recorded the reasons for the decision, the P IPA referred to section 10 of the Standards of Proficiency. She advised that '*it would be unusual to write up notes of a conversation that led to a decision being made. However, if a decision is made that is at odds with protocol or normal procedure, it would be advisable, as this*

makes it clear as to why such a decision was made and who made it. This affords a degree of protection to the crew if any adverse incident was to occur'.

46. The P IPA advised that the '*midwife must take responsibility for making decisions about both the mother and baby as they are the specialist'.* She further advised that *'there does not appear to be a clinical reason from a paramedic perspective as to why the mother and baby should have travelled separately'*.

47. The Trust explained that the baby required immediate transport to the hospital, and this led to the decision for separate ambulances. The P IPA advised that she did not consider that the paramedics transported the baby '*immediately*'. She further advised that '*the ambulance crew arrived at approximately 01:25 and did not leave the house until 01:47 (22 minutes). The PRF shows no record of observations being carried out and no treatment being given (other than free flow oxygen during transport). This would imply that this baby was not a 'time critical' patient, did not require resuscitation or on-going assistance'*.

48. The Trust further explained that transporting the complainant and the baby together would have led to a delay, as the complainant had not yet delivered the placenta. The P IPA advised that '*the statement made by the NIAST is not reasonable. There is no evidence (PRF) to support this statement...it is clear from the information contained within the midwives' notes that the placenta had been delivered prior to the arrival of the first ambulance crew and the student nurse also states the placenta has been delivered during the 999 call'*. The P IPA further advised that '*the baby was reported as responding normally and had been handed back to mother so this would suggest the initial urgency had resolved and therefore any delay at that point would have been of little consequence'*.

49. The P IPA was asked questions regarding the method of transport used for the baby within the ambulance. In relation to whose responsibility it was to decide on the appropriate method of transport for the baby, she advised that '*the Internal Memo [the NIAST Memo] states the responsibility lies with the MLU*

staff (Midwifery Led Units) who have (according to the memo) all been trained in the use of restraint devices'.

50. In relation to who made the decision regarding the method of transport used for the baby within the ambulance, the P IPA further advised that '*as there are no statements contained in the evidence from either member of the ambulance crew or the midwives in attendance it is not possible to answer this question although it is usually (in emergency situations) the ambulance crew that would make this decision – although the memo (as referred to above) indicates it should be the midwife'*.

51. In relation to the method of transport used, the P IPA advised that '*it is not possible for me to advise as to the method of transport used to transfer the baby to hospital. No record has been made as to the method used and no statements from the ambulance crew or midwives have been provided as evidence'*. The P IPA was asked if the method of transport used was reasonable and appropriate. She advised that '*if suitable equipment for transporting new born babies was available to the ambulance crew, then the method of transport was unreasonable and inappropriate. In the absence of such equipment the ambulance crew have to make a risk assessment and transport as safely as possible. If adequate equipment is unavailable and a patient is exposed to risk, this should be reported as an adverse incident (using the Trust's incident reporting system) at the earliest opportunity*'.

52. The P IPA was asked, based on the Trust's response, whether the ambulance was equipped to transport a new-born baby. The P IPA advised that '*it does not appear to be the case that the ambulance was equipped to carry a new born baby. The fold down child seat is designed for a child that can support its own head and body rather than a baby. The standard paediatric 'pedi-mate' is a restraint designed to secure a baby/child onto the ambulance stretcher. It is designed however for minimum weight of 4.5kgs (10lb approx.). The birth weight of the baby is unknown but if below this weight the device may not have been suitable. Restraints for new-borns are available but it is not known whether the Trust supply these or whether they recommend using the standard Pedi-Mate against manufacturers advice. Other transport restraints that allow*

baby to travel on mother's chest are available but from the evidence available it would appear that the Trust have not invested in these'.

53. In relation to the method of transport used, the P IPA advised that '*as it had been decided that the baby required transportation to hospital, from the evidence provided and the clear lack of appropriate equipment, the Paramedic made the decision to carry the chid in his arms (according to the complainant) and I am unable to suggest an alternative in this situation. If the family had a car seat suitable for the transportation of a new born this may have been a favourable option and could have been explored'*.

54. The Trust stated that the paramedics did not use the family's own car seat as the paramedic would have been unable to observe and assess the baby. The P IPA advised that she did '*not agree with the reasons given by the Trust. General observation of the baby such as whether it is conscious and responding, breathing rate, its colour and pulse rate can be made by looking at a baby whilst in a car seat. In addition, as long the baby is kept warm, it should be possible to monitor the oxygen saturation levels on a new born by applying a paediatric probe to the baby's hand or foot'*.

55. The complainant believed that the contact the baby had with the paramedic's clothing caused the baby to contract an infection. The P IPA advised that '*there is no evidence to support this theory and that the infection was potentially caused by contact with the paramedic's uniform. However, the records support that the baby was wrapped in blankets and therefore skin contact with the Paramedics uniform would have been unlikely'*.

56. In relation to the question as to whether the paramedics observed the baby as displaying infection markers, the P IPA advised that she was '*unable to state whether the paramedics carried out a visual primary assessment of the baby, however, no record of any visual primary or secondary assessment has been recorded. A record of 'no obs. possible' has been made without explanation as to why no observations at all could be made'*.

57. The P IPA was asked if she would make any recommendations following review of the complaint. The P IPA advised that '*identification of what equipment is available and whether it is fit for purpose needs establishing. If ambulance crews feel the equipment provided is unsafe to use, or they have not been familiarised/trained they should be reporting this under the Trust's incident reporting system and failure to do this is a breach of the HCPC standards'*.

The NIAST's response to the Independent Professional Advice received

58. I shared the independent professional advice I received with the NIAST. In response to the advice provided, the NIAST explained that it was '*sorry to hear of the experience of [the complainant] at what was clearly a stressful time, and would apologise for any additional stress we may [have] caused'*.

59. The NIAST explained that '*the attendant who travelled in the back of the ambulance with [the complainant's] baby on this occasion was an Emergency Medical Technician rather than a paramedic, although their crewmate was a paramedic'*. In relation to the decision to transfer the complainant and the baby separately to the hospital, the NIAST referred to the NIAST memo (2013), which provides guidance on transfers of new-borns and mothers. It explained that the memo '*confirm[s] that midwifery staff will ultimately take responsibility for the decision on combined mother-baby transfers'*.

60. In relation to the method used to transport the baby to the hospital in the ambulance, the NIAST explained that '*NIAS vehicles do carry the Pedi-Mate to facilitate the transfer of babies, but we understand the limitation of this in relation to children under 10 lb in weight as was the case on this call'*. It further explained that *'historically we have promoted the use of the parents' own new-born child seat, with ambulance crews assisting the parents in attaching it to the ambulance seat (given that parents will be more familiar with their individual seat that a crew encountering it for the first time). It is not clear from the patient notes whether this was considered and discounted by the EMT attending the patient'*.

61. The NIAST also referred to other methods used to transport new-born babies to hospital. It explained that it holds BR seats [baby carrier] at station level but these are '*not readily available in an emergency'*. It further explained that '*in cases where we respond to home birth situations, we may often transport the baby on the stretcher with the mother in a general nursing position. I accept that this position needs to be reviewed and this will be raised on our risk register and reviewed by the Trust's medical equipment committee with input from our Risk Manager, Health & Safety Advisor and Assistant Director (Fleet). I welcome the reference to the Kangoofix Neonatal Restraint System as a potential solution for consideration'*.

62. In relation to observations of the baby undertaken, the NIAST explained that it agreed '*with the comments that general observation of the baby could easily have been undertaken by the ambulance attendant, and would advise that our current model of monitor does allow for the full range of paediatric monitoring'*.

63. In relation to complaint that the method of transport caused the baby to contract an infection, the NIAST explained that it noted the comments from the independent advisor regarding this element. It added that *'the absence of further detail from the complainant or her child's medical record makes it difficult for me to advise further on the potential source of infection'*.

The NIAST's response to a draft copy of the report

64. I shared a draft copy of this report with the NIAST. In its response, it explained that '*NIAS carries Ferno Pedi mates[17] in all A&E [accident and emergency] and PCS [patient care services[18]] vehicles. These are rated for children of 10-40lbs (4.5-18kg). All staff are trained in their use during basic training. The pilot seat within all A&E vehicles cover children from 28-47 inches in height and 20-40lbs. All staff are trained during vehicle familiarisation at basic training'*.

[17] Child restraint used in ambulances.

[18] A service that transports patients to and from healthcare facilities, who do not require the skills and interventions of a Paramedic.

65. The NIAST further explained, '*we have a number of BR baby seats which cover infants of weight 0-18kgs and 9-36kgs respectively. These were purchased some time ago and are currently kept at larger stations for deployment as required although their physical size makes routine carriage difficult. A number are also held at our non-emergency ambulance control centre. All PCS are trained in their use at basic training. Larger hospitals who require transfer of infants hold an incubator built on the current Ferno Falcon stretcher*[19]*. Currently they do not require any training as they are a simple fit to the stretcher, but we note that neither the incubator nor the Baby Pod*[20] *have a fixture to secure the child within'*.

The complainant's response to a draft copy of the report

66. I also shared a draft copy of this report with the complainant and she responded with her comments. The complainant explained that upon arrival to her home, the paramedics did not bring a defibrillator or medical bag with them into the house. She also explained that the paramedic commented that he came from '*Lisburn for this'*. She explained that the paramedics made her feel at fault for the call and that she was a '*time waster'*. The complainant also described the paramedic's attitude as '*appalling*'.

67. The complainant also explained that the blanket used by the paramedics to wrap around the baby was from the ambulance. She explained that there are '*airborne infections which could easily have been caught from close proximity with infectious matter on a uniform of a paramedic'*. The complainant further explained that she accepts that '*infection probably never will be nor can be proved to be the cause'*.

Analysis and Findings

Decision to transport the complainant and the baby separately

[19] A type of stretcher used in ambulances.
[20] Equipment used to transfer infants in ambulances.

68. I note that in its response to this complaint, the NIAST explained that '*the baby was transported by the crew as soon as the crew arrived at scene, I am informed that the baby required rescue breaths following delivery and therefore immediate transport was required'*. It also explained that '*the need for immediate transport was due to the period of apnoea along with the potential delay as the mother had not delivered the placenta at the time the crew were ready to leave'*.

69. I reviewed both the PRF and the records documented by the midwives in attendance at the baby's birth. I note that the baby required rescue breaths immediately following his birth and this was the reason for the emergency call. However, I also note that the baby was responding normally and had been returned to his mother by the time the paramedics arrived. Therefore, I accept the P IPA's advice that '*this would suggest the initial urgency had resolved and therefore any delay at that point would have been of little consequence'*.

70. I note that the NIAST explained that '*immediate transport was required'*. It also explained that '*the mother had not delivered the placenta at the time the crew were ready to leave'*. I note from the records that the complainant delivered the placenta at 01:25. I also note that this was approximately the same time the paramedics arrived at the scene. I further note that the student midwife reported to the NIAST call handler during her call at 01:28 that the placenta had been delivered and the ambulance crew were still in attendance. Furthermore, it is documented that the paramedics left with the baby at approximately 01:47. I accept the P IPA's advice that '*the statement made by the NIAST is not reasonable*'. I consider that there was a period of approximately 20 minutes between the paramedics arriving and leaving with the baby. The records document that the complainant delivered the placenta approximately 20 minutes prior to the first ambulance crew leaving. Therefore, I accept the P IPA's advice that '*there does not appear to be a clinical reason from a paramedic perspective as to why the mother and baby should have travelled separately'*.

71. I note that the NIAST memo states that '*MLU [midwifery led unit] staff will assess the clinical requirement for a baby to travel with their mother in an ambulance*'. I also note that the complainant's maternity records document that the midwife in attendance completed an SBAR and provided it to the paramedics. I also considered the SEHSCT's response to the complaint. I note that the SEHSCT informed the complainant that '*the midwife is the lead professional and following communication with the ambulance team, the midwife makes the decision'.* I further note that the SEHSCT informed the complainant '*you should have both travelled together to the Ulster Hospital Maternity Unit. I apologise that this was not the case and you were separated from your son at a very difficult time'*.

72. I consider that it is unclear from the records available as to who made the final decision for the complainant and her baby to travel to the hospital in separate ambulances. However, I accept the P IPA's advice that the responsibility for making this decision '*should have been taken by the midwives (as they are the specialists in the field of obstetrics)'*. I note that the SEHSCT also accepted that this decision ultimately rested with the midwives in attendance. I also note that the midwife in attendance informed the NIAST that the ambulance crew acted '*in accordance with her wishes'*. Therefore, I do not consider that the NIAST was responsible for the decision for the baby to travel in a separate ambulance to his mother. **I do not uphold this element of the complainant's complaint.**

73. In relation to the recording of this decision, I note the P IPA's advice that '*it would be unusual to write up notes of a conversation that led to a decision being made*'. I note that the NIAST explained that the '*the ambulance staff should have documented the name of the midwife and the instructions that the midwife issued onto the relevant patient report form…these learning points need to be actioned and brought to the attention of the relevant NIAS staff*'. I welcome this learning identified by the NIAST.

Method used to transport the baby to hospital

74. I note that the records document that the baby was wrapped in a blanket and was transported to the hospital in the arms of the attending paramedic.

75. In relation to the equipment available to transport the baby, I note the P IPA's advice that '*it does not appear to be the case that the ambulance was equipped to carry a new born baby'*. This investigation has established that the attending paramedics did not consider using the baby's infant carrier in the ambulance. I note their view that this method would not have allowed the attending paramedic to observe the baby during the journey to hospital. However, I note that the P IPA did '*not agree with the reasons given by the Trust'.* I accept the P IPA's advice that '*general observation of the baby such as whether it is conscious and responding, breathing rate, its colour and pulse rate can be made by looking at a baby whilst in a car seat. In addition, as long [as] the baby is kept warm, it should be possible to monitor the oxygen saturation levels on a new born by applying a paediatric probe to the baby's hand or foot'*. I consider that the crew ought to have considered using the infant carrier as a method of transporting the baby in the ambulance.

76. I am unable to determine from the records available whether it was the midwives or the ambulance crew who made the decision of which method to use to transport the baby to hospital. However, I note the P IPA's advice that '*in the absence of such equipment, the ambulance crew have to make a risk assessment and transport as safely as possible. If adequate equipment is unavailable and a patient is exposed to risk, this should be reported as an adverse incident (using the Trust's incident reporting system) at the earliest opportunity'*. I note that the NIAST's Untoward Incident policy describes an 'untoward incident' as *'any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation*'. I also note that the policy requires staff to report such incidents to their line manager and to their risk manager. However, there is no evidence to suggest that an untoward incident was reported in this instance. The First Principle of Good Administration, 'Getting it Right', requires bodies to act in accordance with its policy and guidance. I consider that the paramedics ought to have reported the

lack of appropriate equipment to safely transport a new-born infant in the ambulance as an untoward incident in accordance with its policy. I consider the failure to do so maladministration.

77. I note that Paramedic 1 explained that he considered other methods of transport for the baby, which were *'eliminated for various reasons'.* However, having reviewed the records, there is no evidence to suggest that the ambulance crew documented their assessment or any decision making process undertaken. Standard 10 of the HCPC Standards of Conduct states that *'you must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to'*. I consider that the paramedics in attendance failed to meet this standard. The maintenance of full and contemporaneous records can act as a shield for a public body to defend its actions when challenged. A failure to follow guidance does not meet the requirements of the First Principle of Good Administration 'Getting it Right'. Furthermore, failures to complete full and accurate records, and to give reasons for decisions, do not meet the requirement to be 'open and accountable' (Third Principle of Good Administration). I consider this failure in record-keeping maladministration.

78. I have considered the NIAST memo which provides guidance to staff in this situation. I note that it advises staff to ensure that the child is secured appropriately. However, the memo fails to inform NIAST staff about appropriate equipment to use when transporting a new-born infant to hospital. The Third Principle of Good Administration, '*being open and accountable',* requires bodies to be *'open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete'*. I consider that the NIAST ought to have provided appropriate guidance to its staff on appropriate equipment to use when transferring new-born infants to hospital by ambulance based on their birth weight. I have not been provided with any evidence to suggest that this occurred. I consider that this constitutes maladministration.

Cause of infection

79. The complainant said that the method used to transport her baby caused him to become unwell. She explained that he would have had contact with Paramedic 1's uniform, which would have been exposed to other ill patients in his role as a paramedic. I also note that she explained that the blanket used to wrap the baby was from the ambulance. She complained that this caused the baby to contract an infection.

80. I note from his clinical records that the baby was admitted to hospital following his birth and treated for an infection. The records document that his CRP level indicated an infection the day after he arrived at hospital (11 March 2018). I note the P IPA's advice that '*the records support that the baby was wrapped in blankets and therefore skin contact with the Paramedics uniform would have been unlikely'.* I also note the complainant's view that the blanket could also have spread infection to the baby as it was from inside the ambulance. However, I am unable to conclude whether or not contact with the paramedic or the blanket used caused the baby to contract the infection. I note that in her response to a draft copy of this report, the complainant accepted that the cause of infection would be difficult to prove.

81. I examined the NIAST records relating to the baby's transfer to consider if any observations taken suggested onset of an infection. I note that the records do not document any observations taken of the baby during his journey to the hospital. I also note the P IPA's advice that '*no record of any visual primary or secondary assessment has been recorded. A record of 'no obs. possible' has been made without explanation as to why no observations at all could be made'*. I can find no reason why the attending paramedic did not take the necessary observations of the baby during his journey to hospital. I consider this a failure in the care and treatment of the baby. I am satisfied that this caused the baby to experience a loss of opportunity for his medical observations to be considered as part of his ongoing plan of care. I note that the NIAST agreed '*with the comments that general observation of the baby could easily have been undertaken by the ambulance attendant, and would*

advise that our current model of monitor does allow for the full range of paediatric monitoring'.

82. Although I have not upheld all of the complainant's concerns, I have identified a number of failings (paragraphs 75, 76, 77 and 80). I consider that the failures identified caused the complainant to experience the injustice of anxiety and upset.

83. I note the complainant's views regarding the conduct of the paramedic who attended her home. However, this issue is outside the remit of this investigation. Whilst I did not investigate and make a finding on this issue, I can understand why, if this was the complainant's experience, the encounter caused her to be distressed.

Issue 2: Whether the NIAS's handling of the complaint was in accordance with NIAS policy and appropriate standards?

Detail of Complaint

84. The complainant said that the NIAST did not take her complaint '*seriously*'. She complained that the investigating officer (IO) corresponded with her by phone only. She further complained that the IO informed her that the '*paramedics were told I could not travel by the midwifes [sic] and he would write up the report for me'*. She complained that she received a letter explaining that the complaints manager believed she [the complainant] was content with the outcome. The complainant explained that she contacted the NIAST to advise that she was not satisfied. However, she complained that the NIAST did not return her call.

Evidence Considered

Legislation/Policies/Guidance

85. In relation to this element of the complaint, the NIAST Complaints Policy was considered. The following relevant extracts were identified:

'***2.0 ROLES & RESPONSIBILITIES…***

Investigating Officers are responsible for…

…2.16 contacting staff identified as the subject of a complaint or enquiry and providing them with a full account of the reasons for the investigation, giving them a proper opportunity to contribute to the investigation, ensuring they are kept informed of progress and receive a copy of the written response;

2.17 ensuring all investigations are conducted in a fair and just manner supportive to those involved and discourages the attribution of blame;

2.18 during the process of the investigation, as appropriate, obtaining written statements and reports from relevant staff. The Investigating Officer may also need to speak to or meet with the person making the complaint or enquiry and review the health or social care records;

2.19 analysing the information obtained from the investigation and making sure adequate information is available to respond to all of the issues raised in the complaint or enquiry;

2.20 liaising with the relevant Assistant Director or Director as to whether a meeting with the person making the complaint or enquiry is appropriate before a response is issued including who might be best placed to meet with the person making the complaint or enquiry…

2.22 ensuring that an 'audit trail' and records are kept of the investigation for retention on file within the Complaints Office in the event that the Northern Ireland Ombudsman requests these as part of an investigation'.

The NIAST's response to investigation enquiries

86. In its response to investigation enquiries, the NIAST explained that *'the investigating officer considers that he took the complaint seriously and acted promptly to establish all the facts. In doing so I reported back to the complainant my finding. [The IO] has also stated, 'the midwife I spoke to at the time…was the midwife on duty on the night of the complainant's home birth. My response to the complaint was hinged on information she gave me regarding what her expectations would be of the crew. As the midwife would have medical primacy at this type of call, the crew acted appropriately. I believe I explained this to the complainant and highlighted she should speak to the midwife team''.*

87. The NIAST was asked for a copy of its notes of any telephone calls or meetings it had as part of the investigations process. The NIAST explained that there was no additional paperwork related to the investigation. It further explained that the IO '*did not fully document his investigation as he was adopting an informal resolution method to what he thought was a straightforward and easily resolved complaint'*.

The NIAST's records

88. I carefully considered the NIAST's records relating to the complaint.

89. The letter of complaint, dated 12 April 2018, states '*I'd like to formally complain. About [sic] being separated from my newborn at birth on Saturday 10 March 2018 at approximately 1.30am'*. It also states, '*it is with regret I write this letter but I do feel this was unacceptable and I would like a detailed explanation of why this happened. I look forward to a speedy response to why this happened as I have already emailed and received no response'*.

90. The NIAST provided a copy of the local complaint resolution form completed by the IO. In relation to the complainant's desired outcome, the form states, '*the complainant feel [sic], if the driver in particular is remorseful of his actions and accepts he was wrong then retraining would be appropriate, however if he shows no remorse she would be keener for a more formal process to commence'*.

91. The records document that the IO contacted the Area Manager for the relevant division on 24 April 2018. The letter states, '*I would be grateful if you could arrange for an investigation into the issues raised within this complaint and provide a report on the outcome of the investigation, addressing any specific issues raised within the complaint and provide recommendations if required'*.

92. The local complaint resolution form completed by the IO further states, '*following the telephone discussion with the complainant, contact was made with the midwife who was in attendance at the complainant's home birth. She*

was very clear that the ambulance crew acted appropriately and in accordance with her wishes. She stressed that at the time they arrived the mother had not delivered her placenta and therefore could not have travelled in the ambulance. As the child had a period of apnoea at birth she would not have wished for any delay in the transfer to hospital. The midwife also questioned the mothers concern regarding the infection, she remembers markers were only slightly raised and the infection risk was high due to the environment of the birth. Therefore it would be difficult to direct blame [at] the ambulance crew as the source of the infection'.

93. The form also states, *'a follow up call was made to the complainant (9/5/18). The discussion with the midwife was relayed and I explained the ambulance crew would be expected to follow the guidance of a specialist at scene, in this case the midwife. I informed the complainant of a meeting with the crew where we discussed communication and how it may have failed in this case and the risk of making assumptions when other healthcare professionals are at [the] scene. The complainant accepted our position, although she disputed the time frames, she recognised the issue is now with the midwife unit. The complainant recognises it is not my place to question the midwife and she plans to pursue them herself'*.

94. I considered the response to the complaint, dated 10 May 2018. The letter states, '*I understand that NIAS Station Officer…has contacted you to discuss your complaint and you are content that this matter has now been resolved. I would like to apologise for your experience with the ambulance service on this occasion. If you would like to discuss any aspect of this matter further, please do not hesitate to contact me. I would thank you for taking the time to provide us with your valued feedback'*.

Analysis and Findings

95. The complainant said that the NIAST did not take her complaint '*seriously*'. I note that in her letter, she stated that she wished to '*formally complain'*. She also stated that she '*would like a detailed explanation of why this happened'*.

96. I note that paragraph 2.16 of the NIAST Complaints Policy states that IOs are responsible for '*contacting staff identified as the subject of a complaint or enquiry and providing them with a full account of the reasons for the investigation, giving them a proper opportunity to contribute to the investigation, ensuring they are kept informed of progress and receive a copy of the written response'*. I carefully considered the file relating to the complaint in accordance with its Complaints Policy. I note that the subjects of the complaint were the attending paramedics. However, there is no evidence to suggest that the IO contacted the ambulance crew and provided them with an opportunity to contribute to the investigation. I note that the IO wrote to the Area Manager for the relevant division on 24 April 2018, requesting her to arrange for an investigation into the complaint. However, there is no evidence that this request was responded to. There is also no evidence that the IO followed up this request when no response was received. Therefore, I do not consider that the NIAST acted in accordance with paragraph 2.16 of its Complaints Policy.

97. I note that paragraph 2.18 of the NIAST Complaints Policy states *'the Investigating Officer may also need to…review the health or social care records'*. It is clear that the complaint concerned the paramedics' care and treatment of the complainant and the baby. Therefore, I consider that it was appropriate in this instance for the IO to conduct a review of the relevant clinical records. I note that the IO stated on the local complaint resolution form that he spoke with the midwife in attendance at the home birth. He documented that the midwife '*stressed that at the time they arrived the mother had not delivered her placenta and therefore could not have travelled in the ambulance'*. However, the clinical records clearly state that the complainant delivered the placenta approximately 20 minutes before the paramedics left with the baby. I consider that the IO would have made the same conclusion had he reviewed the clinical records and the recordings of both 999 emergency calls made by the student midwife. Therefore, on the balance of probability, I do not consider that the IO conducted a review of the relevant clinical records as part of the investigation.

98. I note that in its response to investigation enquiries, the NIAST explained that the IO '*did not fully document his investigation'*. Paragraph 2.22 of the NIAST Complaints Policy states that IOs ought to ensure '*that an 'audit trail' and records are kept of the investigation for retention on file within the Complaints Office in the event that the Northern Ireland Ombudsman requests these as part of an investigation'*. I do not consider that the NIAST acted in accordance with this section of its Complaints Policy.

99. I have identified a number of failings in the NIAST's investigation of the complaint. I identified that there was no evidence to suggest that the IO provided the subjects of the complaint the opportunity to contribute to the investigation. There is also no evidence to suggest that the IO undertook a review of the relevant clinical records as part of the investigation. Furthermore, the IO failed to create and retain appropriate records of the investigation. Therefore, I consider that the NIAST failed to act in accordance with its own Complaints Policy.

100. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. Furthermore, the Fourth Principle of Good Complaint Handling, 'acting fairly and proportionately' requires bodies to ensure that '*complaints are investigated thoroughly and fairly to establish the facts of the case'*. I consider that the NIAST failed to act in accordance with these Principles in its handling of the complaint. I am satisfied that this constitutes maladministration.

101. I note that the IO explained that he adopted '*an informal resolution method to what he thought was a straightforward and easily resolved complaint'*. I consider that it is for the complainant to decide whether they wish to follow a formal or informal process. I note that the complainant stated in her complaint that she wished to '*formally complain'* and that she would like a '*detailed explanation of why this happened*'. I also considered the NIAST's local complaints resolution form for the complaint. In relation to the complainant's preferred outcome to her complaint, the IO documented '*the complainant feel*

[sic], if the driver in particular is remorseful of his actions and accepts he was wrong then retraining would be appropriate'. There is no evidence to suggest that the complainant's preferred outcome was achieved.

102. I note that it is further documented in the same section of the form, '*however if he shows no remorse she would be keener for a more formal process to commence'*. I consider that it was clear from the complainant's letter and her conversation with the IO that she wished the NIAST to initiate a formal complaints process. This would provide her with a clear explanation of the events following her son's birth. However, the NIAST took the decision to close the complaint, stating in its letter, '*I understand that NIAS Station Officer…has contacted you to discuss your complaint and you are content that this matter has now been resolved*'. The Third Principle of Good Complaint Handling, 'being open and accountable', requires bodies to provide *'honest, evidence-based explanations and giving reasons for decisions'*. There is no evidence to suggest that the complaint was considered under a formal process. As a result, I do not consider that the NIAST provided the complainant with '*the detailed explanation of why this happened'* that she specifically requested in her complaint letter. I consider that this constitutes maladministration.

103. I am satisfied that as a result of the maladministration I have identified above (paragraphs 96 and 98) caused the complainant to experience the injustice of the loss of opportunity to receive a detailed explanation of the events that occurred following the birth of the baby. Furthermore, I am satisfied that it also caused the complainant the time and trouble by bringing her complaint to this office.

CONCLUSION

104. The complainant submitted a complaint to this office about the care and treatment provided to her and her son by paramedics following his home birth on 10 March 2018. She also complained about the NIAST's handling of her subsequent complaint.

105. The investigation established that the midwives in attendance had primacy in deciding whether or not the baby would travel with his mother to the hospital. The Trust also accepted that the decision lay with the midwives as the specialists in that particular situation. Furthermore, I am unable to conclude whether or not the actions of the paramedic who held the baby in the ambulance caused him to contract an infection.

106. The investigation found failures in the baby's care and treatment in relation to the following matters:

i. The failure of the paramedics to record their assessment of appropriate equipment to use when transporting the baby in the ambulance;
ii. The failure of the paramedics to report an untoward incident regarding the lack of appropriate equipment available to transport a new-born infant in the ambulance;
iii. The NIAST's failure to provide appropriate guidance to its staff on methods of transport for new-born infants in ambulances;
iv. The failure of the paramedics to take and record appropriate medical observations of the baby during his journey to hospital; and
v. The Trust's handling of the complaint process.

107. I am satisfied that the maladministration I identified caused the complainant to experience the injustice of anxiety and upset.

108. In relation to the NIAST's handling of the complaint, I am satisfied that the maladministration I identified caused her to experience the injustice of the loss of opportunity to receive a detailed explanation of the events that occurred following the birth of the baby. Furthermore, I am satisfied that it caused the complainant the time and trouble of bringing her complaint to this office.

Recommendations

109. I note that in its response to the IPA received, the NIAST explained, '*I accept that this position needs to be reviewed and this will be raised on our risk register and reviewed by the Trust's medical equipment committee with input*

from our Risk Manager, Health & Safety Advisor and Assistant Director (Fleet). I welcome the reference to the Kangoofix Neonatal Restraint System as a potential solution for consideration'. In its response to a draft copy of this report, the NIAST also explained, '*we welcome again the suggestions put forward by the independent review team and can confirm that the matter will be reviewed by the Medical Equipment Group*[21] *which has the remit to introduce such equipment trust wide'*.

110. The NIAST also explained that the '*investigating officer for this complaint has identified that the ambulance staff should have documented the name of the midwife and the instructions that the midwife issued onto the relevant patient report form. [It was] also highlighted the importance of clear communication for all parties during such incidents…these learning points need to be actioned and brought to the attention of the relevant NIAS staff*'. I welcome these learnings already identified and commend it for its efforts.

111. I recommend within **one** month of the date of this report:

i. The NIAST provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the anxiety, upset and the loss of opportunity caused to her as a result of the maladministration identified;

ii. The NIAST reminds staff charged with the responsibility of investigating complaints of the requirement to undertake a robust investigation and the importance of documenting and retaining appropriate records of the process; and

iii. The NIAST implement an action plan to incorporate the following recommendations and should provide me with an update within **six** months of the date of my final report. That 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 related policies) to:

[21] The Medical Equipment Group reviews the latest medical devices to see how they might influence or improve the care provided by NIAS crews.

(i) Review the NIAST memo and consider the inclusion of a section relating to the equipment to be used when transporting an infant weighing under 10lbs in an ambulance;

(ii) Provide training to relevant staff on the equipment to be used when transporting an infant weighing under 10lbs in an ambulance. This training also ought to include use of the NIAST's incident reporting system; and

(iii) Undertake an audit of record keeping to include a review of a random sample of records created by paramedics. These records ought to be benchmarked against the HCPC Standards. The NIAST ought to include any recommendations identified in its update to this office.

PAUL MCFADDEN
Acting Ombudsman **March 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.